Office Supreme Court, U.S.
FILED
SEP 4 1981
ALEXANDER L. STEVAS,
CLERK

No. 80-1690

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

AMERICAN MEDICAL ASSOCIATION, CONNECTICUT STATE MEDICAL SOCIETY, NEW HAVEN COUNTY MEDICAL ASSOCIATION, INC.,

Petitioners,

vs.

FEDERAL TRADE COMMISSION,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

JOINT APPENDIX

NEWTON N. MINOW
SIDLEY & AUSTIN
One First National Plaza
Chicago, Illinois 60603
(312) 329-5400
Counsel for Petitioner American Medical Association

LINDA L. RANDELL
WIGGIN & DANA
195 Church Street
New Haven,
Connecticut 06508
(203) 789-1511
Counsel for Petitioners Connecticut State Medical Society and New Haven County Medical Association, Inc.

REX E. LEE
Solicitor General
Department of Justice
Washington, D. C. 20530
(202) 633-2201
Counsel for Respondent

Petition for Certiorari Filed April 8, 1981
Certiorari Granted June 22, 1981

TABLE OF CONTENTS

		PAGE
1.	Motion of Respondent American Medical Association For Reconsideration Of Issuance Of The Complaint In This Docket (January, 1977)	1
2.	AMA Articles of Incorporation (1902)—CX 1355	10
3.	Opinion of the Judicial Council of the American Medical Association in the Appeal of Ben E. Landess, M.D. (1955)—RX 274	17
4.	Purposes and Responsibilities of the American Medical Association (1967)—RX 2	23
5.	Excerpts from Opinions and Reports of the Judicial Council (1971 edition)—CX 462	25
6.	Excerpts From 1974 AMA Report on Physician-Hospital Relations—CX 959	56
7.	Report Of The Judicial Council On Community Professional Directories (1974)—RX 5	68
8.	May 29, 1975 letter from Bruce Nortell to Larry S. Boress—CX 717	69
9.	Excerpts From Opinions and Reports of The Judicial Council (1977 edition)—RX 1	71
10.	Excerpt of Testimony of C. H. William Ruhe, M.D.—Tr. 5182-85	87
11.	Sturdivant et al., "Comparative Analysis of the American Medical Association vs. Other Associations" (1977)—RX 743	89
12.	Feldstein, "An Analysis of the Sturdivant Report" (1978)—CX 2586	165
13.	Excerpts from "Primary Medical Care Directory, New Haven 1976"—RNHX 109	193
14.	Excerpts From "Primary Medical Care Directors", Revised Edition—RNHX 149	199

PAGE

15. Excerpts From "The Doctors Directory (1977-1978) Tucson-Green Valley"—RX 526 205

16. Excerpts From "Physicians Directory for Whatcom County" (Revised Edition, 1976), Fairhaven College—RX 415 215

17. Excerpts From "Consumer Directory of Pittsburgh Primary Care Physicians" (1976)—RX 666 220

18. Excerpts of Testimony of Bruce Nortell, Esq.—Tr. 4308-4312, 4333-4354, 4360-4361 242

19. Testimony of Michael Halberstam, M.D.—Tr. 7688-7735 261

20. Excerpts of Testimony of Franz J. Ingelfinger, M.D.—Tr. 5329-5336, 5340-5342, 5345-5348, 5368-5369 296

21. Testimony of Robert H. Ebert, M.D.—Tr. 9308-9425 307

22. Excerpts of Testimony of Stephen Biering, M.D.—Tr. 9533-34, 9545, 9547-48 391

23. Excerpt of Testimony of Robert B. Hunter, M.D.—Tr. 9660-9661 395

24. Excerpts of Testimony of Robert Stone, M.D. 397

25. Excerpt of Testimony of William Helme, M.D.—Tr. 7254 400

26. Testimony of AMA Consumer Witness # 1 (Tr. 6695-6722) 401

27. Testimony of AMA Consumer Witness # 3 (Tr. 6794-6820) 422

28. Testimony of AMA Consumer Witness # 5 (Tr. 6854-6871) 441

29. Examples of Physician Advertising 454

UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

In the Matter of THE AMERICAN MEDICAL ASSOCIATION, a corporation, THE CONNECTICUT STATE MEDICAL SOCIETY, a corporation, THE NEW HAVEN COUNTY MEDICAL ASSOCIATION, INC.	Docket No. 9064

To: The Federal Trade Commission

MOTION OF RESPONDENT AMERICAN MEDICAL ASSOCIATION FOR RECONSIDERATION OF ISSUANCE OF THE COMPLAINT IN THIS DOCKET

Respondent American Medical Association, by its attorneys, hereby moves that the Federal Trade Commission reconsider issuance of the complaint in this docket in light of several factors unknown to the Commission at the time the case was brought. This action was instituted approximately one year ago—without any advance notice to respondents and, insofar as respondents have been able to ascertain, without any factual investigation. Until last November, the vagueness and breadth of the complaint prevented respondents from knowing precisely what is at issue in this proceeding. At that time, complaint counsel suggested at a prehearing conference that his case will probably focus around two basic issues:

> (1) Whether the Principles of Medical Ethics of the American Medical Association restrain physicians from advertising or soliciting patients, and, if so, whether such restraint violates § 5(a) of the Federal Trade Commission Act; and

(2) Whether the Principles of Medical Ethics of the American Medical Association restrain physicians from providing medical care by means other than the fee-for-service mode, and, if so, whether such restraint violates 5(a) of the Federal Trade Commission Act.

Respondent American Medical Association respectfully submits that facts unknown to the Commission before the filing of the case and developments occurring since then require re-examination by the Commission of its current approach to consideration of these issues.

A. Advertising and Solicitation

Even before the filing of the complaint, the Judicial Council of the American Medical Association had on November 29, 1975 reviewed the position of the Association with respect to advertising and solicitation by physicians and had instructed its staff to prepare language reflecting its conclusion. This process led, on April 9, 1976, to the issuance of a clear and unequivocal "Statement on Advertising and Solicitation" by physicians. This Statement, which was published in the April 19 issue of *American Medical News* (circulation 280,000) and in the May 24 issue of the *Journal of the American Medical Association* (circulation 245,000), is attached hereto as Appendix A.

The Statement explicitly permits "advertising", the making of information about physicians available to the public. It proscribes only "solicitation", *specifically* defined as the attempt to obtain patients by us of statements that contain testimonials, are likely to create unjustified expectations of favorable results, imply that the physician has superior skills, or otherwise deceive the consumer. The restriction on solicitation is directed only against those forms of promotion of medical services which most informed people would agree are highly questionable and

undesirable. See, for example, the promotional piece from the December 12, 1976 issue of the *Los Angeles Times*, attached hereto as Appendix B.

The Statement of the Judicial Council represents the considered policy of the American Medical Association, a policy arrived at after careful deliberation on how the public interest can best be served.* It takes into account the need of consumers to receive information about the availability of medical services, the need of physicians freely to express themselves, the need to prevent unscrupulous physicians from disseminating false or deceptive information, and the need to avoid the dangers to the physician-patient relationship inherent in certain forms of solicitation. And it is not in conflict with the most recent expression of Congressional intent on the subject, § 1311(b) of the Health Maintenance Organization Act of 1973 [42 U.S.C. § 330e-10(b)], the last sentence of which implicitly sanctions bans on solicitation by individual health professionals.**

The Statement has received the praise of consumer groups. Shortly after its publication, the Director of the

* Although issued after the filing of the complaint, the Statement is not a radical departure from traditional AMA policies made for purposes of this case—as complaint counsel has sought to characterize it. Rather, it is in keeping with a whole line of statements by the Judicial Council. Thus, in December, 1974, a full year before the commencement of this proceeding, the Judicial Council stated, "It is not unethical for a physician to authorize the listing of his name and practice in a directory for professional or lay use which is intended to list all physicians in the community on a uniform and non-discriminatory basis. The listing shall not include any self-aggrandizing statement or qualitative judgment regarding the physician's skill or competence."

** This sentence provides as follows: "This subsection does not authorize any advertising which identifies, refers to, or makes any qualitative judgment concerning, any health professional who provides services for a health maintenance organization.

Public Citizens Health Research Group, the Director of the Public Citizens Litigation Group, and a staff attorney from Public Citizen Litigation wrote the President of the AMA:

> "We congratulate the A.M.A. for the recent statement issued by its Judicial Council . . . . Although we have disagreed on most topics in the past, we are encouraged that the A.M.A. has taken the lead over other professional organizations . . . in accepting the principle that the public is entitled to know about the details of a physician's practice, including information about fees."

More significantly, the April 9 Statement of the Judicial Council has received the endorsement of the courts. Very recently, it has been cited with approval in *Health Systems Agency of Northern Virginia* v. *State Board of Medicine*, F. Supp. , (E.D.Va., Nov. 4, 1976) (three-judge court). The Court noted:

> "The Agency's proposal reasonably protects the public from being misled . . . . Indeed, it is quite similar to the position on advertising stated by the Judicial Council of the American Medical Association. The Council does not proscribe advertising in reputable directories. It approves listing the type of practice, office hours, biographical data, and other useful and relevant information. It also allows the physician to publish his charge for a standard office visit, or his fee or range of fees for specific types of services, provided disclosure is made of the variable and other pertinent factors affecting the amount of the fee specified." BNA Antitrust Trade Reg. Rpt. # 789 (Nov. 16, 1976), at D-4

Indeed, the Court published the Statement in its entirety as Appendix B to its opinion.

In view of the April 9 Statement, the Commission should re-examine the necessity of further proceedings in this docket. Quite apart from this Statement, however, yet another consideration requires a re-examination of the

propriety of this docket. Now before the Supreme Court is a case which is expected to cast much light on the issue of advertising by professionals. In *Bates and O'Steen* v. *State Bar of Arizona,* Dkt. No. 76-316 (Appeal docketed Sept. 30, 1976), the Supreme Court will decide a case involving restrictions on advertising by attorneys. The Court's opinion will most likely deal with and possibly dispose of many of the issues in this proceeding.

Particularly in view of the pendency of *Bates,* the Commission should re-examine whether this is the time to intervene in efforts of physicians to regulate themselves in a manner consistent with the public interest. For such self-regulation is precisely the sort of result which the Commission should seek to encourage.

B. Provision Of Medical Care By Means Other Than The Fee-For-Service Mode

At the same time as it authorized the review of its position on advertising and solicitation, the Judicial Council directed its staff to undertake a complete revision and updating of the *Opinions and Reports of the Judicial Council of the AMA* (1971 ed.). It recognized that many of the statements contained therein either had been made in connection with conditions no longer existing or reflected positions no longer adhered to by the AMA. The Association's current policies on contract practice of medicine, for example, are best reflected, not in the *Opinions and Reports,* but in the 1974 Report on Physician-Hospital Relations. That document, which was included in the Proceedings of the House of Delegates, summarized in *American Medical News* (distributed to every member of the AMA), published separately in booklet form (over 5,000 copies distributed), and sent to each state and large county medical society, provides as follows:

"Medicine's Attitude Toward Medical Care Plans

The AMA recognizes that under proper legal authority such plans may be established and that a physician may be employed by, or otherwise serve, a medical care plan without violating the Principles of Medical Ethics. It believes that in the operation of such plans physicians should not be subjected to lay interference in professional matters and that their primary responsibility should be to the patients they serve.

Organized medicine believes that physicians should be represented on the plan's governing board and that the appropriate state or county medical society should be represented on the plan's medical advisory board. The AMA believes that the nature and extent of benefits provided, and the limitations therein, should be clearly set forth to beneficiaries and physicians. The Association believes that those who receive medical care benefits as the result of collective bargaining should have the widest possible choice from among medical care plans for the provision of such care. It also holds that free choice of physician is the right of every individual. He should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care and should have the right to choose between these alternatives."

The current AMA position on contract practice is further reflected in the Report of the Judicial Council on "Advertising, Physicians, and Health Management Organizations and Health Plans." That Report, adopted by the House of Delegates in December, 1974 and given a very wide circulation, states as follows:

"It is not unethical for a physician to provide medical services to members of a prepaid medical care plan or to members of a health maintenance organization which seeks members (or subscribers) through advertising its services, facilities, charges or other nonprofessional aspects of its operation as long as such advertising does not identify, refer to or make any

> qualitative judgment concerning any physician who provides service to the members or subscribers." *

When this proceeding was instituted, both of these statements were unknown to the Commission and, insofar as respondent can gather, to complaint counsel.

Similarly, neither the Commission nor complaint counsel knew that the staff of the AMA Judicial Council was already at work on a major overhauling of the *Opinions and Reports* when this action was filed. Indeed, the *Opinions and Reports* were withdrawn from circulation last July in anticipation of publication of a substantially updated edition in 1977.** A number of the opinions which led to the withdrawal of that brochure are within the area of provision of medical care by means other than the fee for service mode. These opinions would have been deleted or substantially altered even in the absence of this proceeding. In these circumstances, the recent observation of the Court of Appeals has significance for this case:

> "Compliance is more important than punishment and we question the value of pursuing a course of action which will impede it." *Kennicott Copper Corp.* v. *FTC*, 1976-2 Trade Cases ¶ 61,162 (10th Cir. 1976).

As a result of this case, the American Medical Association has been forced to engage in protracted and financially debilitating litigtaion to defend statements that do not even reflect its own current policy. Surely, there must be a

---

* The foregoing qualification is intended to prevent deceptive advertising which would lead prospective members to believe that the services of an individually named physician who has a reputation for outstanding professional skill would be routinely available to all members having need for his kind of services if in fact this is not so. However, the publication by name of the roster of physicians who provide services to members, the type of practice in which each is engaged, and biographical and other relevant information as outlined in the Statement of the Judicial Council re advertising and solicitation is not a deceptive practice.

** Publication of this edition is scheduled for the Spring of this year.

better way! The Commission should defer this proceeding until after the Association has had a reasonable opportunity to modify the *Opinions and Reports*. Respondent is confident that many, if not most, of complaint counsel's concerns would be obviated were it given this opportunity. In sum, fairness, common sense, and economy all suggest that the Commission reconsider issuance of the complaint in this docket.

Conclusion

This is an unusual case. For the first time in its history, the Commission has sought to assert jurisdiction over a non-profit professional association with a one-hundred-and-thirty year history of serving the public. For the first time in its history, the Commission has sought to regulate the ethical principles of an organization of professionals. Yet, the case was instituted without any prior investigation of the facts and without any prior discussion with respondents.

As a result, the case challenges a position on advertising and solicitation which has won the endorsement of consumer groups and of the courts. It challenges positions in other areas which were being deleted or modified without this litigation. And it challenges these positions in a way that is wasteful both for respondents and for the Commission.

The time has come to re-examine whether this case advances the public interest. For the reasons set forth herein,

respondent American Medical Association submits that it does not. Respondent therefore moves that the Commission reconsider the issuance of the complaint in this docket.

Respectfully submitted,

Newton N. Minow
Jack R. Bierig
Sidley & Austin
One First National Plaza
Chicago, Illinois 60603
(312) 329-5400

Of Counsel:
Bernard D. Hirsh
B. J. Anderson
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
(312) 751-6000

CX 1355 AMA Articles of Incorporation (1902)

Certificate No. 139032

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Alan J. Dixon, Secretary of State of the State of Illinois, do hereby certify that the following and hereto attached is a true copy of the Articles of Incorporation and all Amendments thereto, to date, including last Certificate of Change of Registered Agent and Registered Office of AMERICAN MEDICAL ASSOCIATION, • • • • • • • • the original of which is now on file and a matter of record in this office.

IN TESTIMONY WHEREOF, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois. Done at the City of Sprinfield this 15th day of February AD. 1978.*

ALAN J. DIXON
Secretary of State

[SEAL]

AMERICAN MEDICAL ASSOCIATION.

CERTIFICATE OF CHANGE IN ITS ARTICLES OF ASSOCIATION.

STATE OF ILLINOIS, }
County of Cook. } ss.

WE HEREBY CERTIFY, that at an Annual Meeting of the members of the American Medical Association, held at Saratoga Springs, in the State of New York, on the

13th day of June, 1902, the Articles of Incorporation or Association of said American Medical Association were amended in the following manner, (more than four-fifths of the members of said Association present and participating, voting in favor of said changes):

By amending Sections 1 and 2 thereof, by striking out all after said numbers 1 and 2 respectively, and inserting in lieu thereof the following:

"CONSTITUTION, OR ARTICLES OF INCORPORATION.

ARTICLE I.—TITLE OF THE ASSOCIATION OR CORPORATION.

NAME

The name and title of this organization shall be THE AMERICAN MEDICAL ASSOCIATION.

ARTICLE II.—OBJECT OF THE ASSOCIATION, OR CORPORATION.

OBJECT

The object of this Association shall be to federate into one compact organization the medical profession of the United States, for the purpose of fostering the growth and diffusion of medical knowledge, of promoting friendly intercourse among American physicians, of safeguarding the material interests of the medical profession, of elevating the standard of medical education, of securing the enactment and enforcement of medical laws, of enlightening and directing public opinion in regard to the broad problems of state medicines, and of representing to the world the practical accomplishments of scientific medicine, with power to: acquire and hold property, publish Journals,—etc.

ARTICLE III.—COMPOSITION OF THE ASSOCIATION, OR CORPORATION.

COMPOSITION.

SECTION 1. This Association shall consist of Members, Members by Invitation, Honorary Members, Associate Members and Delegates.

MEMBERS

SEC. 2. *Members.*—Members shall consist of such members of the state societies, together with their affiliated local societies, entitled to representation in this Association as shall make application for admission, in writing to the Treasurer, and accompany said application with a certificate of good standing signed by the president and secretary of the society of which they are members, and the annual fee.

MEMBERS BY INVITATION

SEC. 3. *Members by Invitation.*—Members by Invitation shall consist of distinguished physicians of foreign countries who may be invited by the officers of Sections or of the Association. They shall hold their connection with this Association ..... which they are invited, and shall be entitled to participate in all of its affairs, as in the case of members, but they shall not be assessed the annual dues.

HONORARY MEMBERS

SEC. 4. *Honorary Members.*—Honorary Members shall be physicians of foreign countries who have risen to preeminence in the profession of medicine.

ASSOCIATE MEMBERS

SEC. 5. *Associate Members.*—Representative teachers and students of the allied sciences, not physicians, may

become Associate Members by the vote of the House of Delegates.

SEC. 6. *Delegates.*—Delegates shall consist of such members of the affiliated state and territorial medical societies and of the medical service of the United States Army, of the United States Navy, and of the United States Marine-Hospital Service as shall be chosen in accordance with the provisions of the Constitution, or Articles of Incorporation, and By-Laws of The American Medical Association.

HOUSE OF DELEGATES

SECTION 1.—There shall be a House of Delegates which shall consist of (1) delegates elected by the permanently-organized state and territorial medical societies in affiliation with this Association; (2) delegates elected by each of the component scientific Sections of this Association; (3) one delegate each from the medical departments of the United States Army and United States Navy, and one from the United States Marine-Hospital Service.

NUMBER-APPORTIONMENT

SEC. 2.— The total membership of the House of Delegates shall not exceed 150, and the delegates representing the affiliated state and territorial medical societies shall be apportioned among the several affiliated state and territorial medical organizations in direct ratio to their true membership.

ARTICLE V.—SECTIONS.

In order that its appropriate scientific work may be expeditiously and systematically performed this Association shall be divided into Sections, each of which shall be devoted to the encouragement and pursuit of knowledge in one of the recognized branches into which the science and

art of medicine are for convenience dividend. New Sections may be organized, or existing Sections discontinued, from time to time as necessity arises and when authorized by the House of Delegates.

ARTICLE VI.—BRANCHES.

The House of Delegates shall have authority to provide for and to create such branch organizations as may be deemed essential to the promotion of the welfare of the medical profession.

ARTICLE VII.—SESSIONS AND MEETINGS.

The Association shall hold an Annual Session, during which there shall be held daily a General Meeting, which shall be open to all registered members and delegates. The place and time for holding each Annual Session shall be determined for each next succeeding year by the House of Delegates.

ARTICLE VIII.—OFFICERS.

SECTION 1.— The officers of this Association shall be a President, four Vice-Presidents, a Secretary, a Treasurer, and nine Trustees.

HOW ELECTED

SEC. 2.—The officers of this Association shall be elected by the House of Delegates.

TERM OF OFFICE

SEC. 3.— Each officer, with the exception of the Trustee, shall hold office for one year, or until his successor is elected and installed. Three Trustees shall be elected annually by the House of Delegates.

LIMITATION

SEC. 4.— No member of the House of Delegates shall be eligible to any of the offices mentioned in the foregoing sections of this article.

ARTICLE IX.—FUNDS AND APPROPRIATIONS.

Funds for meeting its current expenses and awards from year to year shall be raised by the Association, by an equal assessment of not more than ten dollars annually on each of the members; by voluntary contributions for specific objects; and from the profits of its publications. Funds may be appropriated by the House of Delegates in accordance with the articles of incorporation for defraying the expenses of its annual meetings; for publication; for enabling standing committees to fulfill their respective duties, conduct their correspondence, and procure materials necessary for the comment of scientific investigation by prized .... and for defraying the expenses incidental to specific investigation.

ARTICLE X.—REFERENDUM.

SECTION 1.— The General Session shall have the right to discuss questions referred to it by the House of Delegates, and it may, by a two-thirds vote, order a general referendum on any question pending before the House of Delegates.

SEC. 2— The House of Delegates shall, upon a two-thirds vote of its own members or upon a two-thirds vote of the General Meeting, submit any question, either through THE JOURNAL or by mail, to the general membership for final vote; and if the persons voting shall comprise a majority of the members, the majority of such votes cast shall determine the question, and this vote shall be binding upon the House of Delegates.

ARTICLE XI.—AMENDMENTS.

The House of Delegates shall have authority to amend any article of this Constitution, or Articles of Incorporation, by a three-fourths vote of all the members composing the House of Delegates.

And Section 3 of said Articles of Incorporation was amended by striking out all after the figure 3, and inserting in lieu thereof the following:

"The Management of the aforesaid, The American Medical Association, shall be vested in a Board of Ten Trustees,

. . . . . .

. . . . . .

of said Association or Corporation directed."

AND WE FURTHER CERTIFY, that the said Annual Meeting of said Association, so held at Saratoga Springs, on the 10th, 11th, 12th and 13th days of June, 1902, was, upon motion, duly adjourned on the 13th day of June 1902, to meet at 103 State Street, Chicago, Illinois, on the 16th day of June, that the adjourned session of the Annual Meeting of said American Medical . . . . . .

. . . . . .

this, pursuant to the said adjournment, and that at the said adjourned session of said Annual Meeting, so held in Chicago, Illinois, (more than a Quorum being present), the previous action of the Meeting, in adopting the said Amendments to the Articles of Incorporation, above set forth, were approved by the unanimous vote of all the members present.

IN WITNESS WHEREOF, we have hereunto set our hands and affixed the Seal of said Corporation, this 20th day of June, A.D. 1902.

President

[SEAL] Secretary

RX 274

OPINION OF THE JUDICIAL COUNCIL OF THE AMERICAN MEDICAL ASSOCIATION IN THE APPEAL OF BEN E. LANDESS, M. D.

February 9, 1955

The Board of Censors of the Medical Society of the County of Queens, Inc. (New York) concluded that certain specifications charging Dr. Ben E. Landess with unethical solicitation of patients by advertising had been proved and sustained. This action was adopted by the Queens County Society and affirmed by the Board of Censors and the House of Delegates of the Medical Society of the State of New York. Dr. Landess then appealed to the Judicial Council of the American Medical Association.

Dr. Landess is the Medical Director of the Jamaica Medical Group, which has a contract with the Health Insurance Plan of Greater New York, Inc. (referred to as H.I.P.) H.I.P. offers a form of prepaid medical coverage in the state of New York. The Judicial Council made a careful examination of the specifications, the proceedings, and the oral arguments in this matter. Following this examination and after careful deliberation the Council reached the decision stated in this opinion.

It is important to note that the only question before the Judicial Council is whether Dr. Landess has violated the Principle of Medical Ethics of the American Medical Association pertaining to solicitation of patients by advertising (chapter 1, section 4 of the Principles of Medical Ethics of the American Medical Association). No charge of violation of any other ethic is made. The specification of charges dated November 28, 1951, filed with the Medical Society of the County of Queens, Inc., and the violation state:

CHARGE: The indirect solicitation and procurement of patients by advertising.

VIOLATION: Principles of Professional Conduct of the Medical Society of the State of New York, Chapter 1, section 4 to wit:

That section as there quoted was and is the same as the comparable ethic of the American Medical Association. The action of the Queens County Society adopting the report of its Board of Censors is the same as stated in the specifications of November 28, 1951, except one specification is omitted. Accordingly the Judicial Council must confine its decision to the question of whether Dr. Landess has violated chapter 1, section 4 of the Principles of Medical Ethics of the American Medical Association pertaining to advertising, which reads in part as follows:

> "Solicitation of patients, directly or indirectly, by a physician, by groups of physicians or by institutions or organizations is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician. Among unethical practices are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning cases in which the physician or group or institution has been or is, concerned."

The following appears to be the basis of the decision that Dr. Landess violated the ethic pertaining to advertising: The Queens County Medical Society found that H.I.P. advertised directly to the public and that by means of this advertising Dr. Landess "directly benefits by the solicitation of patients . . . inasmuch as the H.I.P. solicits patients only for the groups of physicians which are contractually bound to it." The specifications refer particularly to advertisements in the *New York World-Telegram & Sun* of November 13, 1951, and November 20, 1951, and a brochure

entitled "A Program of Prepaid Medical Care for Residents of Fresh Meadows Housing Development Only." The Society also concluded that Dr. Landess "is cognizant of some of the above violations. By continuing in association with the H.I.P., despite his knowledge of some or all of these violations, he thereby shows his tacit approval of the unethical solicitation of patients on his behalf by the H.I.P."

The action of Queens County Medical Society does not deprive Dr. Landess of membership privileges at this time. The report specifically recommended that "no action be taken against him," and this report was adopted. The action was in reality an advisory opinion "given for the information and guidance of the members of this Society."

The state and county medical societies agreed that H.I.P. was lawfully organized under a special law of the state of New York and is licensed to do within the state the business in which it is engaged. Further, although the record was not clear until oral argument before us, the nature and quality of the advertising referred to in the specifications was not questioned in this proceeding. In the oral argument the attorney for the societies stated in response to an inquiry as to whether there was any issue respecting the quality or the dignity of the advertising: "I say to you frankly that issue was not raised in the case at all. . . . Incidentally H.I.P. can advertise from today until five thousand years from now; we can't tell them what to do."

There is no charge or any finding that Dr. Landess had anything to do with the preparation or distribution of the advertising or promotional material nor is there anything in the testimony or exhibits to substantiate any such conclusion. Although, as stated, the quality of the advertising is not in issue, it may be pointed out that there is nothing in it extolling the skill or training of Dr. Landess nor is there anything to indicate that it was used by him as a means of self-laudation.

Since on the record before us H.I.P. is organized and operates in accordance with law and may lawfully advertise, since the quality of its advertising is not in issue, and since Dr. Landess had nothing to do with the preparation or distribution of the advertising, it is our opinion contrary to that of the state and county medical societies that the conduct of Dr. Landess does not violate the ethic relating to solicitation and advertising. In view of the advisory nature of the county society's report and since Dr. Landess has not been deprived of any membership privileges, we believe our opinion disposes of this appeal, and no further action by the Judicial Council is called for at this time. We do not mean to imply by our decision in this appeal that a physician can ethically associate himself with an organization that is either unlawful or one that indulges in improper or unethical advertising, nor absolve himself from appropriate disciplinary action by complacence or indifference.

The parties at various stages of these proceedings interjected a variety of subjects, some of which we refer to briefly. In the memorandum filed by Dr. Landess the contention is made and vigorously argued that the county society has hampered and injured H.I.P. in violation of state and federal laws relating to conspiracy and restraints of competition. We do not render any decision on this contention. There is serious doubt, according to our attorneys, that the testimony and exhibits in this case are adequate for us to come to a decision on these matters, a conclusion that was in great part conceded in the oral presentation. Additionally, as Dr. Landess' attorney stated in his argument, "it is scarcely within the competence" of physicians to evaluate these complex and elusive legal problems.

The printed and oral arguments also devoted considerable time to the character of the Jamaica Medical Group and

its arrangements with H.I.P. The county and state societies have argued that the arrangements between H.I.P. and the members of the H.I.P. groups deny free choice of physician. Dr. Landess, on the other hand, contends that this arrangement assures free choice of physician. It is important to note in this connection that neither the charges against Dr. Landess nor the report of the county society refer to the ethic dealing with free choice of physician, although the ethic is mentioned in the written and oral arguments, nor do they tell much about H.I.P. or the relationship between H.I.P. subscribers and the medical groups affiliated with it. It is not clear therefore as to the extent, if any, to which the action taken with respect to Dr. Landess is predicated on this relationship. It is clear that neither the report of the county society obviously have an impact on physicians involved in numerous arrangements of which we may not now be aware.

The American Medical Association has long encouraged the development and use of prepaid medical care plans. Prepaid medical coverage has expanded considerably since World War II and much additional experience has been obtained. Unfortunately, however, some of the plans are susceptible to abuse. In the history of these plans there have been incidents of exploitation and deception of subscribers and physicians and consequent depreciation in the quality of care. Although the Association has encouraged prepaid medical coverage, it has been concerned that the quality of care should not be sacrificed nor the public deceived and defrauded. In this connection, it is vitally important that the traditional patient-physician relationship and professional standards not be debased, otherwise in the long run the quality of medical care will surely suffer. To achieve these objectives, the House of Delegates in 1946 adopted Eleven Standards for Physician-Sponsored Plans

and in 1949 adopted Twenty Principles for Lay-Sponsored Plans, which are relevant to the operation of an organization such as H.I.P. These Standards and Principles, although not amendments to the Principles of Medical Ethics, are certainly to be given full consideration in interpreting and applying them.

An exhaustive study of medical care plans was authorized by the Board of Trustees in December, 1954. The Judicial Council is participating in this study, which will include an analysis and review of the ethical and other problems arising out of the relationship between medical care plans, patients, and physicians. The study referred to will include a thorough analysis of the H.I.P. type of organization, among others. As stated above, the record before us in the appeal of Dr. Landess is inadequate to determine the many ethical problems arising out of H.I.P.'s relationship to its subscribers and physicians if indeed the state and county societies intended to challenge that relationship.

RX 2

Purposes and Responsibilities of the American Medical Association

(1967)

The objects of the American Medical Association, as written into the Association's Constitution more than a century ago, are "to promote the science and art of medicine and the betterment of public health."

This phrase, standing alone, does not clearly define the true purposes of the AMA and therefore has insufficient meaning to the general public. As a result, the purposes of the Association frequently are misunderstood and misinterpreted.

The Board of Trustees recommends that the purposes of the AMA be clearly defined and widely disseminated so that the true objects of the Association will be understood.

Therefore, the Board requests the House of Delegates to approve in principle the Purposes and Responsibilities of the American Medical Association as set forth in this report. It is understood that these policies and objectives will be reviewed from time to time to assure that they remain the prime principles and objectives of the Association.

The Purposes and Responsibilities of the American Medical Association

It is the responsibility of the American Medical Association, as the representative of the American medical profession, to continue to foster the advancement of medical science and the health of the American people.

Its continuing purposes are to meet this responsibility through the following means:

1. By encouraging the further development of medical knowledge, skills, techniques and drugs; and by maintaining the highest standards of practice and health care.

2. By creating incentives to attract increasing numbers of capable people into medicine and the other health-care professions.
3. By advancing and expanding the education of physicians and other groups in the health-care field.
4. By motivating skilled physicians who have the art of teaching to apply themselves to developing new generations of excellent practitioners.
5. By fostering programs that will encourage medical and health personnel to serve voluntarily in the areas of need for medical care.
6. By developing techniques and practices that will moderate the costs of good medical and health care.
7. By seeking out and fostering means of making all health-care facilities—physicians' offices, hospitals, laboratories, clinics and others—as efficient and economical as good medical practice and attention to human values will permit.
8. By combining the utilization of the latest knowledge for prevention and treatment with the vital healing force of the physician's personal knowledge of and devotion to his patient.
9. By maintaining the impetus of dedicated men and women in providing excellent health care by preserving the incentives and effectiveness of unshackled medical practice.
10. By maintaining the highest level of ethics and professional standards among all members of the medical profession.
11. By continuing to provide leadership and guidance to the medical profession of the world in meeting the health needs of changing populations.

Excerpts from CX 462

Opinions and Reports of the Judicial Council

(1971 edition)

INTRODUCTION

The Judicial Council, a standing committee of the House of Delegates, consists of five active members of the AMA elected by the House on nomination by the President for terms of five years. The duties of the Council, as defined in Section 11 (A) of Chapter XI of the AMA Bylaws, are set forth in the appendix. The Council's Rules of Procedure follow. Opinions of the Judicial Council and actions of the House of Delegates relating to the Principles of Medical Ethics are then set forth.

Ethical principles are basic and fundamental. Men of good conscience inherently know what is right or wrong, and what is to be done or to be avoided. Written documents attempt to express for the guidance of all what each knows to be true. Thus the Principles of Medical Ethics are truly guides to good conduct.

The Judicial Council presents this guide as a practical usable reference for all who wish to use it. As problems arise, the Council will consider them in the light of basic principles for the benefit of all members of the public and the profession.

1972

HISTORY

The earliest written code of ethical principles for medical practice was conceived by the Babylonians around 2500 B.C. That document, the Code of Hammurabi, was indeed a *code* of conduct, setting forth in considerable detail for that era of history the nature of conduct demanded of the

physician. Today that code would be subject to criticism because it went into too much detail. It may be doubted that it could have continued, as a practical document, through the centuries because, as medical science and cultural patterns became more complex, it would have required one skilled in jurisprudence to codify and interpret the myriad situations covered by it.

The Oath of Hippocrates, a brief statement of principles, has come down through history as a living and ever workable statement of ideals to be cherished by the physician. This Oath was conceived some time during the period of Grecian greatness, probably in the fifth century B.C. It protected rights of the patient and appealed to the inner and finer instincts of the physician without imposing sanctions or penalties on him. Other civilizations subsequently developed written principles, but the Oath of Hippocrates (Christianized in the tenth or eleventh century A.D. to eliminate reference to pagan gods) has remained in Western Civilization as an expression of ideal conduct for the physician.

The most significant contribution to ethical history subsequent to Hippocrates was made by Thomas Percival, a physician, philosopher, and writer of Manchester, England. In 1803, he published his *Code of Medical Ethics*. His personality, his interest in sociological matters, his close association with the Manchester Infirmary, led to the preparation of a "scheme of professional conduct relative to hospitals and other charities," from which he drafted the code which bears his name.

At the first real meeting of the American Medical Association in Philadelphia in 1847, the two principal items of business were the establishment of a code of ethics and the creation of minimum requirements for medical education and training. Although the Medical Society of the State of New York and the Medico-Chirurgical Society of Balti-

more had had formal written codes of medical ethics prior to this time, it is clear from the records and the preface to AMA's first adopted Code of Ethics that it was based on Percival's Code.

In general, the language and concepts of the original Code adopted by the Association in 1847 remained the same throughout the years. There were revisions, of course, which reflect the temper of the times and the eternal quest to express basic concepts with clarity. Major revisions did occur in 1903, 1912, and 1947. In 1957 the language of the chapter dealing with compensation of physicians, contract practice, conditions of medical service, free choice of physician, and purveyal of medical services was redrafted.

In December, 1955, an attempt was made to distinguish medical ethics from matters of etiquette. A draft of a two-part code seeking to accomplish this was submitted to the House of Delegates at that time but was not accepted. This proposal was, in effect, a segregation of then existing statements, found in the *Principles,* into two categories. Little or no change was made in the language of the forty-eight sections of the *Principles.*

Subsequently, in June, 1956, a seemingly radical proposal was submitted to the House of Delegates for consideration. This proposal, a short version of the *Principles,* was discussed at the following session of the House, in December, 1956, after having had wide publication and broad consideration among members of the medical profession. It was then laid over for final consideration at the June, 1957, meeting of the House of Delegates, at which meeting the short version was adopted.

The format of the *Principles* adopted in June, 1957, is a change from the format of the *Principles* promulgated by Percival in 1803 and accepted by the Association in 1847. Ten short sections, preceded by a preamble, "succinctly express the fundamental concepts embodied in the present

[1955] Principles," according to the report of the Council on Constitution and Bylaws. That Council assured the House of Delegates in its June, 1957, report that "every basic principle has been preserved; on the other hand, as much as possible of the prolixity and ambiguity which in the past obstructed ready explanation, practical codification and particular selection of basic concepts has been eliminated."

Almost immediately after the 1957 edition of the *Principles of Medical Ethics of the American Medical Association* was adopted, the Judicial Council of that Association expressed its formal opinion that:

> ". . . the 1957 edition of the *Principles* was not intended to and does not abrogate any ethical principle expressed in the 1955 edition of the *Principles of Medical Ethics of the American Medical Association.* The format and language of the 1955 and 1957 editions differ; certain items dealing with professional manners and etiquette have been eliminated. However, the basic ethical concepts they include are identical. Therefore, no opinion or report of the Council interpreting these basic principles which were in effect at the time of the revision has been rescinded by the adoption of the 1957 edition . . ."

PRINCIPLES OF MEDICAL ETHICS

Preamble

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1

The principal objective of the medical profession is to render service to humanity with full respect for the dignity

of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

SECTION 2

Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

SECTION 3

A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

SECTION 4

The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

SECTION 5

A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

SECTION 6

A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a determination of the quality of medical care.

SECTION 7

In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

SECTION 8

A physician should seek consultation upon request in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

SECTION 9

A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

SECTION 10

The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

• • • • •

SECTION 5

A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may

discontinue his services only after giving adequate notice. He should not solicit patients.

1. *Choice of Patient; Patient May Not Be Neglected*

A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice to the patient, his relatives or his responsible friends sufficiently long in advance of his withdrawal to allow them to secure another medical attendant.

2. *Emergency Cases in Absence of Personal Physician*

When a physician is called in an emergency because the personal or family physician is not at hand, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the personal or family physician. However, he should first report to the personal or family physician the condition found and the treatment administered.

3. *Precedence When Several Physicians Are Summoned*

When several physicians have been summoned in a case of sudden illness or of accident, the first to arrive should be considered the physician in charge. However, as soon as is practicable, or on the arrival of the acknowledged personal or family physician, the first physician should withdraw. Should the patient, his family or his responsible friend wish some one other than him who has been in charge of the case, the patient or his representative should advise the personal or family physician of his desire. When, because of sudden illness or accident, a patient is taken to a hospital without the knowledge of the physician who is known to be the personal or family physician, the patient should be returned to the care of the personal or family physician as soon as is feasible.

4. *A Colleague's Patient*

When a physician is requested by a colleague to care for a patient during the colleague's temporary absence, or when, because of an emergency, a physician is asked to see a patient of a colleague, the physician should treat the patient in the same manner and with the same delicacy that he would wish used in similar circumstances if the patient were his responsibility. The patient should be returned to the care of the attending physician as soon as possible.

5. *Substitution in Obstetric Work*

When a physician attends a woman who is in labor because the one who was engaged to attend her is absent, the physician summoned in the emergency should relinquish the patient to the first engaged, on his arrival. The one in attendance is entitled to compensation for the professional services he may have rendered.

6. *Solicitation of Patients, Direct or Indirect*

Solicitation of patients, directly or indirectly, by a physician, or by groups of physicians, is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician. Among unethical practices are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning cases in which the physician or group or institution has been, or is, concerned. Self-laudations defy the traditions and lower the moral standard of the medical profession; they are an infraction of good taste and are disapproved.

7. *Acceptable Advertising*

The most worthy and effective advertisement possible, even for a young physician, especially among his brother physicians, is the establishment of a well-merited reputa-

tion for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct.

8. *Solicitation of Patients by Groups*

Many of the questions submitted to the Council involve the subject of solicitation of patients. As is well-known, there is a tendency for physicians to organize themselves into so-called groups under various designations, such as group clinics, diagnostic clinics, group medicine, medical institutes, the (blank) medical academy, and similar names. Some of these groups are advertising in a manner that would be considered most reprehensible if done by an individual physician. The Council is unable to see any difference in principle between a group of physicians advertising themselves under whatsoever title they may assume and an individual physician advertising himself.

9. *Local Societies must Review Questions Concerning Solicitation of Patients*

A great many communications have been received with respect to advertisements used by individual physicians, groups, clinics, and hospitals owned by individuals or groups. Members of the state associations who use objectionable advertising are responsible to and under the control of the censorial agencies of the societies of which they are members. Communications complaining about conduct of physicians who are thought to be soliciting patients should be directed to the secretary of the constituent medical association concerned, with the request that they be brought to the attention of the board of councilors, or through them to the attention of the board of censors of the component society concerned.

10. *Solicitation of Patients and Requirements of Law*

Complaint has come that physicians have permitted their names to be posted in factories and elsewhere in such a

manner as to conflict with the Principles of Medical Ethics which prohibits solicitation of patients. Here again the laws of the states obtrude, since some of them specifically provide that an industry or an employer must post the names of physicians whose services are available to employees.

The determination of some questions of ethics must depend on the law; and the individual state medical association, as it holds original jurisdiction in such matters, must consider these questions, deal with them in the light of the law and seek to effect needed corrections.

11. *Solicitation of Patients or Patronage*

The Principles of Medical Ethics proscribe the solicitation of patients or patronage. Solicitation, as used in the Principles, means the attempt to obtain patients or patronage by persuasion or influence. However, the public is entitled to know the names of physicians, the type of their practices, the location of their offices, their office hours, and the like. The doctor may ethically furnish this information through the accepted local media of communication, which are open to all physicians on like condition. Telephone listings, office signs, professional cards, dignified announcements, all are acceptable media of making factual information available to the public.

The particular use to be made of any medium of communication and the extent of that use are, however, matters to be determined according to local ideals. What constitutes an excess, what is not in keeping with the ideals of medicine and what amounts to solicitation are questions of fact. The application of this principle is to be made locally.

12. *Commercialization of Medical Procedure—Abortion*

The commercialization of the medical procedure of abortion is condemned in the strongest terms possible.

Regardless of one's convictions concerning abortion, either therapeutic or economic, all must unite in protesting commercialization and hucksterism in this sensitive area.

Even though laws have been liberalized and abortions are permitted for therapeutic or other reasons, the procedure remains a medical procedure. If it is to be done, it must be done strictly in accord with the highest standards of medical practice. The rights of the patient must be respected and ethical principles observed just as in any other medical procedure.

The ethical principle remains: no physician may solicit patients. A physician may not do indirectly that which he may not do directly. He may not permit others to solicit patients for him.

The medical profession, county and state medical societies, and also the *public* must cooperate to preserve and protect the highest standards of medical practice in all its aspects. The establishment of abortion mills must not be permitted.

13. *Holding "Open House" Not in Itself Unethical*

Section 5 of the Principles proscribes the solicitation of patients. If the intent for having the "open house" is to solicit patients, even indirectly, then it would be contrary to the Principles. If, however, motivation for holding open house stems from civic and natural pride in having made a contribution to the community and to medicine then the practice may not be objectionable. In the latter instance the holding of an open house might have the effect of acquainting the citizens of the community with some of the improvements developed for better patient care, comfort, and convenience. It might tend to convince the public that there is no apathy on the part of doctors when it comes to improving all facets of medical care.

Before a physician or a group of physicians hold such an open house, however, it is incumbent on him or them to discuss the proposal with appropriate officers of the component medical society. Communities and customs differ.

The local society must assess local custom and usage and insure that neither the dignity of medicine nor local custom and tradition are offended by any particular practice of doctors.

14. *Follow-up Announcement*

It is ethical for doctors to remind patients that certain follow-up examinations are needed or are desirable or that certain treatments should be taken care of. Of course, such announcements may be sent only to bona fide patients of the doctor. They should be in good taste and should not serve to advertise the doctor or extol his abilities. Certainly no ethical physician would wish to use this device as a subterfuge for solicitation of patients, nor would he wish to engage in this practice if it were considered contrary to local customs and usages. County medical societies might well establish a framework within which the sending of follow-up notices might be conducted.

15. *Removal Notice When Physician Leaves Community*

Not only is it ethical for a physician to notify his patients of the fact that he is leaving his practice, it is necessary that he do so. The physician has an affirmative ethical obligation to notify his patients of this fact in sufficient time to permit them to obtain the services of other physicians before he leaves the community. A doctor must not abandon his patients.

16. *Announcements Concerning the Opening or Removal of a Physician's Office*

On opening an office a physician may properly send announcements to his colleagues, to his intimate personal friends not in the medical profession, and to those persons in allied fields with whom it may reasonably be expected he will associate. Announcements of the opening of an office should not be mailed indiscriminately to all persons in the community, nor should commercial mailing lists be

utilized. A brief news item carried in the local press, in itself, is not unethical. Local societies may, however, in the exercise of good judgment determine and fix limitations in this regard.

On removing an office a physician may properly advise of this fact to the same persons and in the same manner as he may announce the opening of an office. In addition, he may, and should advise his patients of the essential facts concerning this removal. In any case, the physician is well advised to check with the appropriate officer or committee of his local medical society in order to conform his conduct with local practice.

17. *Form of Announcement Concerning the Opening or Removal of a Physician's Office*

No form has been approved by the American Medical Association. Under the Principles of Medical Ethics and in keeping with the ideals of the profession, it would seem that no objection would be made to a simple statement of fact, without undue embellishment, e.g.:

> John Doe, M.D. announces the opening (the removal) of his office at (followed by location or locations, in case of removal). Office hours, telephone number, and a statement concerning limitation of practice, if applicable, may be included.

The above suggestion is to be understood as advisory only and is not to be considered an exclusive form that must be used. In all cases the local society can be looked to for an authoritative opinion.

18. *Listing of Name in a Commercially Sponsored Advertising Directory*

The Principles proscribe the solicitation of patients directly or indirectly. The House of Delegates of the Association has expressed disfavor with the practice of permitting one's name to be listed in a commercial advertising directory because it is or may be interpreted to be the

indirect solicitation of patients. In 1936, a resolution was introduced in the House of Delegates. It reads as follows:

> "Whereas, certain commercial interests are publishing medical directories, listing physicians by specialty and otherwise, as available for insurance and compensation work, and other professional services, and whereas, participating by listing in these lay publications merely serves for the profit of the promoters and is furthermore technically indirect solicitation of patients, be it Resolved that the Arkansas Medical Society condemns these practices as unethical and forbids its members to continue listing their names in such directories and be it further resolved that the Arkansas Medical Society requests the House of Delegates of the American Medical Association to take similar action."

Most, if not all, listings of physicians by specialty in directories published by commercial concerns, are but subtle ways of avoiding the pronouncement of the Principles of Medical Ethics concerning solicitation of patients, under a guise of buying a directory when the real intent is the purchase of the publication of the buyer's name in the directory for the purpose of obtaining patients.

A physician who uses or permits the use of his name in a commercial directory that fails to include on like terms and without discrimination the names of all licensed physicians practicing in the area served by the directory has the burden of proving that his action is in keeping with the Principles.

19. *Indication of Medical Society Qualification*

The physician should limit the use of statements of professional qualifications on letter and billheads and professional cards to the simple, dignified abbreviation "M.D." or the statement "Doctor of Medicine." It cannot be concluded. however, that it is unethical to use specialty designations in this manner.

20. *Use of Proper Advertising Media*

Publication or circulation of simple professional cards is approved in some localities but is disapproved in others. Disregard of local custom and offenses against recognized ideals are unethical. The component medical society must, in the final analysis, determine what practice is in accord with local custom, but in so doing, it should exercise great caution to insure full compliance with the spirit and intent of the Principles. The practice of medicine should not be commercialized nor treated as a commodity in trade. Respecting the dignity of their calling, physicians should resort only to the most limited use of advertising and then only to the extent necessary to serve the common good and improve the health of mankind.

21. *Use of Medical Emblem on Automobile*

Nothing in the Principles of Medical Ethics proscribes the use of a medical emblem by a physician on his automobile. It may be noted that it has long been the custom of the Association to provide for its member at cost, registered medical automobile insignia.

22. *Insignia for Members of Special Groups*

An organization having to do with the certification of physicians requested the opinion of the Judicial Council on the ethical standing of their credential holders should they carry or wear a key indicating their membership in that organization or show on their professional stationery a replica of the key together with initial letters indicating their membership. It was felt that approval of such procedure if given to one group of doctors of medicine could not well be withheld from any other body composed of doctors of medicine desiring to do likewise; that, if such a custom became prevalent, irregular practitioners and cultists would rapidly follow suit; that the display advertising of those lease qualified to give good medical care to the public would be most apparent, and that the confusion in the lay mind would lead to much harm to the indiscriminating public.

23. *Use of Sign*

The Principles of Medical Ethics proscribe the solicitation of patients. It has been an accepted principle that the most worthy and effective advertising is the establishment of a well-merited reputation for professional ability and fidelity; and that disregard of local customs and offenses against recognized ideals are unprofessional. It is the opinion of the Judicial Council that local customs vary from community to community, and therefore it is the obligation of the component medical society to determine whether, in a given locality, the use of any sign by a physician would be an affront to the ideals of the community and bring discredit to the profession. It is the further opinion of the Council that both the physician who contemplates the use of such advertising and his component society should fully observe the precept of the Principles: "A physician is expected to uphold the dignity and honor of his vocation."

24. *Retention of Name of Deceased Physician by Group or Partnership*

The continued use of the name of a decreased member of a group or partnership by those who continue the medical practice of that group or partnership is not of itself a violation of the Principles, if such practice is not contrary to local custom or the law of the community. The practice becomes unethical if it misleads or deceives the public, if it offends against local custom and ideals, or if it is contrary to law. Whether such practice tends to or does deceive or mislead depends on all the facts of each situation and includes both the intent of the user and the anticipated effect such practice will have in the particular community. Only the component medical society can ascertain these facts and determine from them whether the practice is or is not in violation of the spirit and intent of the Principles. Better practice dictates, if the name may properly be used, some means to indicate that the former member is deceased; for example, John Doe, M.D., 1880-1954. In some exceptional situations the continued use of the name of

the deceased by his surviving associates may well be a fitting tribute to the memory of one who contributed materially to the advancement of medicine.

25. *Continued Use of Name of Deceased Physician by Succeeding Physician*

The Judicial Council was asked if it is ethical for a new physician in a community, who purchased the practice of a deceased physician, to continue the use of the deceased physician's name in his practice, in telephone listings, etc.

In and of itself, it is not unethical for a new physician in a community, who has purchased the practice of a physician, whether the physician be deceased or not, to continue the use of the former physician's name in his practice for a reasonable length of time. It is preferable, however, for a new physician to establish his own name in the practice of the profession as quickly as possible.

26. *Advertisement on Physician's Appointment Card*

Carrying or listing the name of an insurance company, drugstore, a business concern, or the like on a physician's professional medical appointment card is unprofessional.

27. *Distribution of Reprints of Articles*

One normally would not take it upon himself to mail reprints indiscriminately without sufficient reason. What constitutes a sufficient reason is impossible to define categorically. Certainly it would not be ethical for a physician to mail reprints if his intent was to solicit patients directly or indirectly or to attempt to bring undue attention to himself. The practice, therefore, cannot be recommended. This is not to say that the author of a medical article may not honor requests for copies of his article.

28. *Use of Physician's Name in Connection with Civic Enterprises*

The use of a physician's name in connection with a civic project should not, in itself, be considered contrary to the Principles of Medical Ethics.

29. *Use of Physician's Name in News Story*

The Principles of Medical Ethics prohibit the solicitation of patients. They do not prohibit the reporting of proper news. When an accident or event occurs which is newsworthy and if the facts surrounding it are published, there would be no way, and seldom any reason, to stop a newspaper from reporting as a matter of fact that the victim was taken to the offices of a named doctor for treatment. Should the newspaper so report, the doctor should not be criticized because the newspaper made this factual observation.

SECTION 6

A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

1. *Conditions of Medical Practice*

A physician should not dispose of his services under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the patient concerned might be deprived of immediately necessary care.

2. *Contract Practice*

Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita.

Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that

are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered.

3. *Contract Practice*

It will be observed that in the definition of contract practice submitted to the House in 1926 no mention is made of the ethics of the practice for the reason that contract practice *per se* is not an ethical question, ethics being concerned with the form of the contract and the conditions under which it is made. That there are many conditions under which contract practice is not only legitimate and ethical, but in fact the only way in which competent medical service can be provided, becomes evident on analysis.

It is perfectly evident, therefore, if we are to judge whether a contract is ethical or not, that we must know the form and terms of the contract as well as the particular circumstances under which it is made. As there is such a great variety of contracts, as their form and the circumstances under which they are made differ so widely, it seems impossible, or at least inadvisable, to attempt to define what constitutes an ethical contract. Each case must be judged on its own merits after all the facts pertaining thereto are known.

There are certain points, however, that may be formulated which, when present, definitely determine a contract to be unfair or unethical.

These may be stated as follows:

1. When the compensation received is inadequate based on the usual fees paid for the same kind of service and class of people in the same community.
2. When the compensation is so low as to make it impossible for competent service to be rendered.
3. When there is underbidding by physicians in order to secure the contract.
4. When a reasonable degree of free choice of physicians is denied those cared for in a community where other competent physicians are readily available.

5. When there is solicitation of patients directly or directly.

In the interpretation of the rules of ethics as applied to the practice of medicine: (1) By the word "practice" is meant the performance or application of medical knowledge; (2) by "solicitation" is meant to seek professional patronage by oral, written or printed communications either directly or by an agent; (3) by "patient" is meant any person ill or otherwise.

4. *Purveyal of Medical Service to Direct Profit of Lay Group*

The privilege of healing the sick as a profession is a right granted only to those properly qualified and licensed by the state. It is a privilege belonging only to the medical profession. It is a sacrifice of professional dignity that this exclusive right of medicine is so often sold for individual gain or its possessor deprived of it against his will. In increasing numbers, physicians are disposing of their professional attainments to lay organizations under terms which permit a direct profit from the fees or salaries paid for their services to accrue to the lay bodies employing them. Such a procedure is absolutely destructive of that personal responsibility and relationship which is essential to the best interests of the patient.

Outstanding examples of this type of unearned gain are not difficult to find. There are insurance companies administering workmen's compensation benefits wherein the salaries or fees paid to the physician by the insurance company are so much below the legal fees on which the premium paid by the industry is based as to furnish a large direct profit to the insurance company. Certain hospitals are forbidding their staffs of physicians to charge fees for their professional services to "house cases" but are themselves collecting such fees and absorbing them in hospital income. Some universities, by employing full time hospital staffs and opening their doors to the general public, charging such fees for the

professional care of the patients, as to net the university no small profit, are in direct and unethical competition with the profession at large and their own graduates. They are making a direct profit by a practice of questionable legality, from the professional care.

5. *Physician-Hospital Relations*

A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee.

Where a hospital is not selling the services of a physician, the financial arrangement if any between the hospital and the physician properly may be placed on any mutually satisfactory basis. This refers to the remuneration of a physician for teaching or research or charitable services or the like. Corporations or other lay bodies properly may provide such services and employ or otherwise engage doctors for those purposes.

The practice of anesthesiology, pathology, physical medicine and radiology are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine or any other designated field of medicine.

A physician should not enter into a contract or agreement with a hospital whereby the hospital acts as the agent for a physician unless it is with the consent of the physician and of the medical staff. The physician and the medical staff, as principals, should not approve any contract whose terms or conditions are inconsistent with the "Principles of Medical Ethics" and established policy of the American Medical Association.

6. *Relationship with Hospitals or Unions—Physicians, Residents or Interns*

Whatever an intern or resident's economic relationships with a hospital may be, his responsibility to patients is

primary. No circumstance may be permitted to interfere and cause neglect of patients. Whether interns and residents are members of a union or not, they are bound by the Principles of Medical Ethics and whatever the interns' and residents' economic relationships with a hospital or union may be, their professional conduct must conform to ethical principles.

7. *Anesthesia a Medical Service*

Anesthesia is a medical service and therefore should always be under the direction and supervision of a physician who assumes the responsibility and who should present his bill for services. No hospital or individual without a license to practice medicine should be permitted to collect the fee for anesthesia.

8. *Physicians Employed to Staff Hospital Emergency Room*

The policy of certain hospitals under which physicians are employed on a salary to provide professional medical care in the emergency room on the theory that emergency service in the hospital appears to have developed as an essential hospital function has been considered.

The official policy of the American Medical Association as adopted by the House of Delegates in 1951 and reaffirmed as recently as June, 1964, states that a physician should not dispose of his professional services to any hospital, corporation or lay board by whatever name called under terms or conditions which permit the sale of the services of that physician by such agency for a fee. The action of a physician in accepting a salaried position offered by the hospital in a case such as described is not consonant with the policy of the AMA.

One possible solution to staffing an emergency room is to have the medical staff form itself together into a medical partnership for the purpose of employing a physician

whose duties among others would include taking care of emergency cases in the hospital. The physician would be the employee or agent of the staff rather than the hospital.

9. *Association of Pathologist and Laboratory Technician*

An association between a pathologist and a licensed technician to operate a medical laboratory would involve an improper division of professional income with a lay person. Under such an arrangement, the lay technician would have a direct financial interest in the productivity and fees earned by the pathologist. For this reason such a plan would be unethical.

10. *Relation Between Psychiatrists and Psychologists*

In relationships between psychiatrists and practicing, licensed psychologists, the physician should not delegate to the psychologist any matter requiring the exercise of professional medical judgment.

11. *Practice of Medicine by Lay Corporations*

It was decided long ago that the practice of law by a lay corporation was against public policy and the same has been prohibited by law in many states. The relations between patient and physician are more intimate than are those between client and attorney. It is impossible for that intimacy of relationship to exist between an individual and a corporation and if it is against public policy for a corporation to practice law, how much more so must it be for a corporation to practice medicine.

12. *Lay Corporations*

The practice of medicine by lay corporations is detrimental to the best interests of scientific medicine and of the people themselves. When medical service is made impersonal, when the humanities of medicine are removed, when the coldness and automaticity of the machine are substituted for the humane interest inherent in individual service and the professional and scientific independence of the

individual physician, the greatest incentive to scientific improvement will be destroyed and the public will be poorly served.

13. *Form of Medical Practice*

The House of Delegates affirms that it is within the limits of ethical propriety for physicians to join together as partnerships, associations or other lawful groups provided that the ownership and management of the affairs thereof remain in the hands of licensed physicians.

14. *Professional Association Laws*

The so-called "professional association laws" permit doctors to form professional associations. It was asked whether or not associations of doctors formed under this law would conform to the American Medical Association's Principles of Medical Ethics.

In 1957 the House of Delegates of the Association declared that it is within the realm of ethical propriety for physicians to join together in partnerships, associations, or other lawful groups, provided that the ownership and the management of the affairs thereof remain in the hands of licensed physicians. In accordance with the policy of the House of Delegates, physicians may take advantage of "professional association laws" and may also ethically do those things which are necessary to reap the intended and proper advantage of such legislation.

15. *Professional Corporations*

If the laws of the state provide that physicians may organize professional service corporations for the practice of medicine, it is ethically permissible for physicians to form such corporations. It is implicit in such circumstances that the ownership and management of the affairs of the professional service corporation remain directly and solely under the control of licensed physicians, and that the attending physician remain responsible to his patient.

The ethical principles for the medical practice conducted under the form of a professional service corporation are exactly the same as for the individual physician. The professional service corporation and each physician member of the professional service corporation must observe and follow all the principles of medical ethics.

16. *Names of Professional Corporations*

Groups of physicians who incorporate as professional service corporations or who form professional associations or partnerships may not choose a name for their group which aggrandizes the group, or is of such nature as to mislead the public. The name must be accurate.

17. *Availability of Medical Services*

Many forces are pressing for the adoption of new methods of medical practice and for changes in the relations of physicians, as individuals and as organized groups, toward the public and toward institutions and organizations, and also for revolutionary changes in the very traditions of the profession with respect to the obligations and privileges of physicians in their contacts with one another. These forces have in some instances been sadly misdirected and will result in disaster to medicine and to the public.

The complexities of modern society may make it imperative that some changes shall be made, but the duty of the organized profession is to see to it that any and all proposals for change, from whatever source, shall be scrupulously and deliberately examined with the view of determining their ultimate value. Decisions should not be made on the basis of feasibility for the immediate present but should be made in the light of the experience of the profession, the nature of its service, the imperative need for maintaining professionalism and the absolute necessity for unhampered scientific advancement, and with the utmost regard for the best interest of the people.

• • • • •

4. *Advertising and the Daily Press*

The Principles of Ethics of the AMA define clearly the methods which are objectionable for physicians to use to bring themselves into the public notice in their endeavor to gain a livelihood. They state clearly the methods by which a man may rise by honorable endeavor to the fame of a well-earned reputation, and suggest the different methods by which a man may gain unsavory notoriety. The standards of the medical profession have always demanded that physicians shall not exploit their ability or achievements to the laity. The medical profession condemns such advertising as quackery. The refraining from or the employment of advertising is the clearly defined difference between a reputable physician and a quack—the physician, one who quietly, through his professional work and attainments seeks by daily honorable dealing to spread the truth among his patients; the quack, one who endeavors to obtain his livelihood by playing on the credulity of the ignorant and the timid, imposing on the public statements known to be false, stopping at nothing in his effort to enhance his notoriety or fill his pocket.

The public is eager to hear and learn all it can of the most recent advances in the cure of diseases that so far have baffled the efforts of men to cure; it is eager to hear of the brilliant operations by which men have seemingly been saved from certain destruction and brought back to useful-existence. It is anxious to learn and put in practice the best methods of public hygiene and preventive medicine. The daily press has correctly considered such subjects as news, as that is what interests its daily readers, but the medical profession has been placed at a disadvantage. The members of the profession who value the kind of reputation which they may bear before the public and from whom the most accurate information could be obtained, have been forced

to see the most garbled statements published as medical facts, or have been refused opportunities to have the truth published unless they were willing to put themselves in the false position of self-exploitation. Certain other members of the profession, however, with a very wide-awake commercial spirit, have quickly seen the means by which they may appear in the press as doing extraordinary things above their fellows, and have eagerly seized on the opportunity, to have their picture, their honors and their doings put in the public press. While this may not be quackery it must be acknowledged to be advertising. It is frequently difficult to decide where one ends and the other begins. Certain newspapers have heralded this stepping over the limits of the strict adherence of the profession to its non-advertising principles as something much to be desired. They seemingly fail to understand and appreciate that if the barriers which the medical profession has held up, and still holds up, are broken down, quackery will become more and more rampant, and although the ease with which the press will obtain the sensations it desires will increase, the accuracy and the truth and the value of the news which they so eagerly seek will soon be ruined.

To all questions there are two sides and we must realize that if the AMA endeavors to arouse in the public an interest in medical matters and increase its knowledge of public health and hygiene with this increased knowledge will come a demand for more knowledge concerning the various diseases which may be acquired by any individual. The daily press has a right to publish that which is of interest to its readers; hence it has a right to a knowledge of medical matters that shall be accurate and given by honorable men. On the other hand there is every reason why the medical profession shall keep up its barriers against the self advertising of individuals for selfish purposes and no adequate reason why these barriers should be let down.

The Judicial Council therefore recommends:

That each county society should constitute a publicity committee whose duties shall be to give to the daily press accurate information on all medical matters of interest to the public, that this shall be freely given without the mentioning of names or from whence the information comes, and that this committee shall act in an advisory capacity to all physicians of its society in questions relating to publications other than in the medical press.

5. *Medical Public Relations*

In the ever-expanding field of medical public relations, no single phase has developed more than that which leads to the publication in national lay magazines and newspapers of stories of research or surgery. Such articles, where authoritatively prepared, usually tend to add to public confidence in the procedure described. The members of the Judicial Council believe that public confidence would be greatly enhanced, if a footnote printed with the article set forth the information that the article as written had the approval of the county or state, or both, medical societies.

6. *Physicians Writing Health Columns*

It is not improper for physicians, not in active private practice, to write health columns for lay readers.

AMERICAN MEDICAL ASSOCIATION CONSTITUTION AND BYLAWS

Chapter XI, Section 11
Duties of Judicial Council

(1) The judicial power of the Association shall be vested in the Judicial Council, whose decision shall be final.

(2) The Council shall have original jurisdiction in (a) all questions involving Membership as provided in Division One, Chapter I, Section 1, of the Bylaws; (b) all controversies arising under this Constitution and Bylaws and

under the Principles of Medical Ethics to which the American Medical Association is a party; and (c) controversies between two or more state associations or their members and between a state association and a component society or societies of another state association or associations or their members.

(3) The Council shall have appellate jurisdiction in questions of law and procedure but not of fact in all cases which arise between a state association and one or more of its component societies, between component societies of the same state association, between a member or members and the component society to which said member or members belong or between members of different component societies of the same state association. Notice of appeal shall be filed with the Judicial Council within thirty (30) days of the date of the decision by the state association and the appeal shall be perfected within sixty (60) days thereof; provided, however, that the Judicial Council, for what it considers good and sufficient cause, may grant an additional thirty (30) days for perfecting the appeal.

(4) The Council shall have jurisdiction on all questions of medical ethics and the interpretation of the Constitution, Bylaws and rules of the Association.

(5) The Council at its discretion may investigate general professional conditions and all matters pertaining to the relations of physicians to one another or to the public and may make such recommendations to the House of Delegates or the state associations as it deems necessary.

(6) The Council shall have authority to request the President to appoint investigating juries to which it may refer complaints or evidences of unethical conduct which in its judgment are of greater than local concern. Such investigating juries, if probable cause for action be shown, shall submit formal charges to the President, who shall appoint a prosecutor to prosecute such charges against

the accused before the Judicial Council in the name and on behalf of the American Medical Association. The Council may acquit, admonish, suspend or expel the accused.

RULE IV. *Physicians Denied Membership in Component or Constituent Associations*

Pursuant to Chapter XI, Section 11 (D) (7) of the Bylaws, any physician whose application for membership in a component and/or constituent association has allegedly been denied unfairly because of color, creed, race, religion, or ethnic origin, may appeal to the Judicial Council. The Council shall determine the facts in the case and report the findings to the House of Delegates. If the Council determines that the allegations are indeed true, it shall admonish, censure or, in the event of repeated violations, recommend to the House of Delegates that the state association involved be declared to be no longer a constituent member of the American Medical Association.

Proceedings for such determination shall be initiated by a written statement. Such statement shall: (1) identify the parties to the case, (2) show that the appellant has exhausted remedies made available by the constitution and bylaws of the component society and the state association, and (3) include a concise factual resume of the case in sufficient detail to enable the Council to ascertain the facts. The appellant should also furnish such other information as may be requested by or helpful to the Council in determining the facts.

RULE V. *Original Controversies*

Original proceedings before the Judicial Council shall be initiated by a written statement. Such statement shall include information (1) identifying the parties to the controversy, including membership affiliations, if applicable, and (2) explaining the nature of the controversy, setting forth the provisions of the Constitution, Bylaws, Rules or Principles of Medical Ethics concerned.

RULE VI. *Appeals*

Appellate proceedings before the Judicial Council shall be initiated by a written statement of appeal. Such statement shall include information (1) identifying the parties to the case and indicating membership affiliations when appropriate, (2) showing that the appellant has exhausted remedies made available by the constitution and bylaws of the component society and the state association and (3) describing the error of law or procedure which is believed to have occurred during the proceedings. The statement shall also include a concise, factual resumé of the case. Appellant shall submit with the statement, the charges, complaints, findings, opinions and decisions previously entered in the case.

RULE VII. *Interpretation of the Constitution, Bylaws, Rules and Principles of Medical Ethics of the American Medical Association*

A. *Requests for Interpretation.* Requests for interpretation of the Constitution, Bylaws, Rules or Principles of Medical Ethics of the Association shall be in writing and shall describe the matter to be interpreted in sufficient detail to enable the members of the Judicial Council to valuate the request in all its aspects.

CX 959—Excerpts From 1974 AMA Report On Physician-Hospital Relations

Physicians with Salary or Other Contractual Arrangements with Hospitals Primarily for Patient Care

A great deal of controversy has been generated by the employment of physicians by hosiptals or contractual arrangements between them to provide services. The AMA's basic position regarding this practice is capsulized in a recommendation of the 1964 *Report on Physician-Hospital Relations:*

> . . . a physician should not bargain or enter into a contract whereby any hospital, corporation or lay body by whatever name called or however organized may offer for sale or sell for a fee the physician's professional services. Further, it is recommended that it be the policy of the American Medical Association that a physician shall not enter into a contract or agreement with a hospital whereby the hospital acts as the agent for a physician unless it is with the consent of the physician and of the medical staff. The physician and the medical staff, as principals, should not approve any contract whose terms or conditions are inconsistent with the "Principles of Medical Ethics" and established policy of the American Medical Association.

Throughout many years, it has clearly been AMA's position that no lay organization should profit from fees received for physicians' services.

RECOMNENDATION 6:

> It is recommended that, in states where legally permissible, in contracts between individual physicians and hospitals that involve in whole or in part the provision of professional medical services to patients, it be recognized that one method of practice is for the physician to accept the guarantee of a stipulated income from the hospital for his patient care services. Fees available for the physician's professional medical services should be billed by the physician or, with the

consent of the medical staff, by the hospital acting as his agent. Where the hospital acts as the physician's agent, its billing shall clearly delineate the fee for the physician's professional services. If fees collected for the physician's professional medical services exceed the stipulated income guarantee, any excess amount shall be payable to the physician and shall be under his direct control.

Concerning contractual arrangements with groups for staffing emergency rooms, the AMA approved the following arrangement in 1964:

The employment of licensed physicians by a medical partnership or corporation, approved by the medical staff, and composed of all or part of the members of the medical staff with billing and remuneration for such professional services to be on any mutually satisfactory arrangement between the medical partnership or corporation and the employed physicians. Where there is reimbursement through insurance and prepayment mechanisms or other agencies for any part or all of such professional services, the medical partnership or corporation may obtain such payments.

Another policy, adopted in 1967, is not limited to emergency room physicians:

Groups could be established for limited functions, for example, to provide medical care to patients admitted to the hospital without a personal physician on the attending staff.

The group could include all members of the medical staff or it could be limited to members of a specific department. It could include medical staff members in private practice, as well as full- and part-time salaried physicians and faculty, if any.

The group would collect, control and disburse all income generated by its activities. Disbursement would be according to a plan previously agreed upon.

The AMA has continuously held the position that the principles of medical ethics apply to *all* physicians, including those employed by or under contractual arrangements

with hospitals, and whether in solo, partnership, or group practice.

In considering physicians' fees available from private insurors, prepayment plans, and government programs, the AMA has consistently supported the position that these should be separated from payments for hospital services. Both private and government agencies have been strongly urged to separate these reimbursements and generally have been willing to do so.

In recent years, there has been a very large shift in contract arrangements of pathologists and radiologists and hospitals toward fee-for-service and away from arrangements such as percentage of gross or net in the department and straight salary. The April 16, 1972, issue of *Hospitals, J.A.H.A.*, documents these arrangements in an article by Bergole, et al, entitled "Hospital-Specialist Compensation Plans."

Another development has been the formation of so-called physicians-on-call groups. These groups (now developed in California, Illinois, and New York, for example) provide services in a number of communities on a temporary or a long-term basis, according to need. In many communities, their prime function is to provide staffing for hospital emergency departments. Relatively little literature is available on them, and research regarding their effectiveness is lacking.

• • • • •

Private Practice Considerations

When the doctor enters the employment of a hospital as a full-time director of medical education, he is not violating current AMA policy, since his function is an educational one. A salaried chief of service or program director whose duties are primarily related to education is similarly not in violation of policy.

Depending upon the hospital, private practice by these salaried physicians may be necessary for them to maintain their clinical experience and thus enhance their teaching ability.

Whether such private practice is legal and ethical will depend upon the facts in each case.

A 1956 AMA report, "Private Practice by Medical School Faculty Members," recommended:

> . . . that it be the policy of the American Medical Association that funds received from the private practice of medicine by salaried members of the clinical faculty of the medical school or hospital should not accrue to the general budget of the institution and that the initial disposition of fees for medical services from paying patients should be under the direct control of the doctor or doctors rendering the service.

The body of the 1951 statement notes that, in their relationships with hospitals, physicians should be guided not only by the laws of the verious states, but also by the Principles of Medical Ethics.

The 1951 statement was reaffirmed at the 1959 Clinical Convention and stated to supersede all intervening or inconsistent actions. A review for inconsistent actions was made by the Committee on Medical Facilities of the Council on Medical Service. The Council's findings were reported to the House at the June 1960 meeting as follows:

> . . . It finds that in June 1953, the House approved the Report of the Joint Committee on Hospital-Physician Relationships of the Boards of Trustees of the American Medical Association and the American Hospital Association. This report stated "the right of an individual to develop the terms of his service on the basis of local conditions and needs is recognized, but such contractual arrangements should in all cases ensure (a) the operation of professional incentive for the physician, and (b) progressive development of the hospital departments involved, in order that increasingly improved services to patients may be rendered. More-

over, a physician shall not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual by whatever name called or however organized, under terms of conditions which permit exploitation of the patient, the hospital or the physician."

In September 1953, the Chairman of the Association's Judicial Council answered an inquiry regarding physician-hospital relations. The answer, based principally on an interpretation of the Principles of Medical Ethics stated that it was not the sense or intent of the Principles "to establish as ethical or to proscribe as unethical any particular financial arrangement—any term or condition—by which a physician disposes of his professional attainments or services . . ." The letter also stated that the Principles of Medical Ethics "proscribe not one, not the most flagrant but every act which permits the professional attainments and services of a physician to be exploited for the financial profit of any agency—for all such acts are detrimental to the welfare of the patient and the good of the profession."

In June 1957, the House of Delegates adopted a revised edition of the Principles of Medical Ethics. The Reference Committee on Amendments to the Constitution and Bylaws, which considered the revised edition and recommended their adoption to the House, took special notice of the 1951 Guides and quoted at length from them in its report. It was recommended in the reference committee's report that the House accept and approve the 1957 edition of the Principles and at the same time reaffirm the 1951 Guides. The 1957 edition of the Principles of Medical Ethics was adopted and the 1951 Guides were reaffirmed simultaneously.

The above are the only actions which have been discovered by the Committee on Medical Facilities which bear on the 1951 Guides. It is to be noted that these same Guides also delineate the method of adjudicating individual complaints and settling controversies between physicians and hospitals. The underlying principle of adjudication is that such controversies are to be dealt with at the local level; and that not until there is

> assurance that local and state remedies have been exhausted, is it appropriate for the American Medical Association to enter the controversy.
>
> Thus, the Council believes that these actions enumerated earlier in this report are not inconsistent with the 1951 Guides but instead represent interpretation or efforts to clarify the Guides for practical application.

The House agreed that the actions enumerated in the above report were not inconsistent with the 1951 Guides but represent interpretation or efforts to clarify the Guides for practical application.

In adopting the conclusions and recommendations of the 1964 *Report on Physician-Hospital Relations,* the House of Delegates reaffirmed the 1951 Guides on the Relations of Physicians and Hospitals in their entirety as being sound and widely applicable. The House of Delegates particularly reiterated the following statement from the so-called Hess Report Principles:

> A physician should not dispose of his professional attainments or services to any hospital, corporation, or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee.

However, it was noted that the 1951 statement has frequently been misunderstood and, as a result, has generated unwarranted public criticism. Much of the misunderstanding has resulted from the quoting of portions of this policy statement out of context. The 1951 statement, considered in its entirety, and other policy statements adopted by the House of Delegates indicate that a variety of "terms or conditions" are acceptable, provided that, in the best interest of patient, hospital, and physician, these "terms or conditions" do not interfere with or impair the physician's free and complete exercise of his medical judgment and skill, do not cause a deterioration of the quality of medical care, and do not result in profit for a third party.

Physician Control Over the Collection and Disbursement of Available Fees

While the position of the American Medical Association is clear that a physician should not make his services available under terms or conditions that permit the sale of his services for a fee, there is adequate recognition of the fact that fees are frequently available for professional services provided in the hospital setting. Various statements express the policy of the AMA that these fees, from whatever source available, are to be under the initial control of the physician or physicians providing the service.

Information on the right of the individual physician to initial control over his professional fees was provided in 1963, as follows:

> Resolved, That any assignment or donation of such fees, whether from the individual's own resources or from some prepayment insurance plan, shall be, without any pressure or coercion from other sources, solely at the discretion of the attending physician.

Further, in 1966, in Board of Trustees Report R, it was stated:

> Fees for professional medical services are properly paid only to the responsible physicians and may not be appropriated by any other person or agency. The physician is the sole arbiter as to the ways in which he may dispose of his professional income, without duress, consistent with the laws of the land and the Principles of Medical Ethics of this Association.

Lay Corporations

> The practice of medicine by lay corporations is detrimental to the best interests of scientific medicine and of the people themselves. When medical service is made impersonal, when the humanities of medicine are removed, when the coldness and automaticity of the machine are substituted for the human interest inherent in individual service and the professional and scientific independence of the individual physician, the

greatest incentive to scientific improvement will be destroyed and the public will be poorly served.

Group Practice In Hospitals

In December 1957, the House of Delegates approved Resolution 27, which stated:

> Resolved, that the House of Delegates affirm that it is within the limits of ethical propriety for physicians to join together as partnerships, associations, or other lawful groups provided that the ownership and management of the affairs thereof remain in the hands of licensed physicians.

The AMA has approved group practice in hospitals on several occasions. In 1966, the Judicial Council held that salaried employment in a hospital emergency department under terms or conditions permitting the sale of physician's services for a fee was not consonant with AMA policy. It agreed, however, that

> . . . one possible solution to staffing an emergency room is to have the medical staff form itself together into a medical partnership for the purpose of employing a physician whose duties among others would include taking care of emergency cases in the hospital. The physician would be the employee or agent of the staff rather than the hospital .

In 1964, the House of Delegates approved the following as an "acceptable means for staffing emergency departments":

> The employment of licensed physicians by a medical partnership or corporation, approved by the medical staff, and composed of all or part of the members of the medical staff with billing and remuneration for such professional services to be on any mutually satisfactory arrangement between the medical partnership or corporation and the employed physicians. Where there is reimbursement through insurance and prepayment mechanisms or other agencies for any part or all of such professional services, the medical partnership or corporation may obtain such payments.

At the 1967 Annual Convention, the House adopted Report C of the Council on Medical Service, which offered the establishment of group practice by hospital medical staffs as a means for ensuring physician control over the collection and disbursement of professional fees. According to the report:

> Groups could be established for limited functions, for example, to provide medical care to patients admitted to the hospital without a personal physician on the attending staff.
>
> The group could include all members of the medical staff or it could be limited to members of a specific department. It could include medical staff members in private practice, as well as full- and part-time salaried physicians and faculty, if any.
>
> The group would collect, control and disburse all income generated by its activities. Disbursements would be according to a plan previously agreed upon.

Contract Practice

AMA policy provides guidelines by which groups formed by the medical staff could provide services to patients under a variety of contractual arrangements.

The 1951 *Statement on Relation of Physicians and Hospitals* cited the following sections from the Principles of Medical Ethics then in effect:

> Contract practice.—Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principles or agents, and a corporation, organization, political subdivision or individual whereby partial or full medical services are provided for a group or class of individuals *on the basis of a fee schedule or for a salary or for a fixed rate per capita. Contract practice* per se *is not unethical.* Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions *causes deterioration of the quality of the medical services rendered.* (Emphasis supplied.)

In 1927, the House of Delegates approved a statement setting forth the following points that, when present, definitely determine a contract to be unfair or unethical:

1. When the compensation received is inadequate based on the usual fees paid for the same kind of service and class of people in the same community.
2. When the compensation is so low as to make it impossible for competent service to be rendered.
3. When there is underbidding by physicians in order to secure the contract.
4. When a reasonable degree of free choice of physicians is denied those cared for in a community where other competent physicians are readily available.
5. When there is solicitation of patients directly or indirectly.

In the interpretation of the rules of ethics as applied to the practice of medicine: (1) By the word "practice" is meant the performance or application of medical knowledge; (2) by "solicitation" is meant to seek professional patronage by oral, written or printed communications either directly or by an agent; (3) by "patient" is meant any person ill or otherwise.

In adopting the conclusions and recommendations of the 1964 *Report on Physician-Hospital Relations*, the House of Delegates stated:

> . . . a physician should not bargain or enter into a contract whereby any hospital, corporation or lay body by whatever name called or however organized may offer for sale or sell for a fee the physician's professional services. Further, it is recommended that it be the policy of the American Medical Association that a physician shall not enter into a contract or agreement with a hospital whereby the hospital acts as the agent for a physician unless it is with the consent of the physician and of the medical staff. The physician and the medical staff, as principals, should not approve any contract whose terms or conditions are inconsistent with the "Principles of Medical Ethics" and established policy of the American Medical Association.

Principles Governing Groups and Clinics

The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee, or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

Inclusion of Professional Services in Insurance and Prepayment Contracts

The Conclusions and Recommendations of the 1964 *Report on Physician-Hospital Relations* noted that the physician-hospital relationship is complicated because of the "inclusion of medical services in contracts of voluntary hospital service plans." The Report referred to Resolution 27 (C-60), as adopted, which urged:

> All constituent associations to take such actions as may be deemed necessary to effect the transfer of professional services from Blue Cross plans and all other hospitalization plans to Blue Shield or that section of insurance plans providing for professional service, wherever such situations exist.

The 1964 Report noted a 1961 finding of the Council on Medical Service that "the crux of the problem is not in the contracts written by insurance companies or prepayment plans but is one of relationships between hospitals and physicians at the local level." It added that "many hospitals do not base their charges on departmental costs. Where this is true, they tend to resist transfer of insurance coverage for professional services, since 'profits' realized from some departments are used to offset many other costs of hospital service."

The 1964 Report made the following recommendation, which was adopted:

> It is therefore recommended that medical staffs, state and component medical societies, and specialty so-

cieties, be urged to implement Resolution 27 by all appropriate means, including consultation with hospital associations, governing authorities and administrators to bring about equitable cost accounting and cost-related charges.

At the 1965 Annual Convention, the House of Delegates adopted the following resolution:

> Resolved, that this House of Delegates record itself as approving and supporting the principle that Blue Shield medical-surgical insurance benefits should be paid only to private physicians for eligible professional services personally rendered to their private patients.

Physician Faculty Members

In June 1956 the report of the Council on Medical Service on "Private Practice by Medical School Faculty Members" was adopted by the House of Delegates. The report contained the recommendation:

> ... that it be the policy of the American Medical Association that funds received from the private practice of medicine by salaried members of the clinical faculty of the medical school or hospital should not accrue to the general budget of the institution and that the initial disposition of fees for medical services from paying patients should be under the direct control of the doctor or doctors rendering the service. It is the firm policy of the American Medical Association, and in this policy the Council heartily concurs, that only a licensed doctor of medicine should practice medicine. It is not in the public or professional interest for a third party to derive a profit from payment received for medical services, nor is it in the public or professional interest for a third party to intervene in the physician-patient relationship.

RX 5

AMERICAN MEDICAL ASSOCIATION
REPORT OF THE JUDICIAL COUNCIL

COMMUNITY PROFESSIONAL DIRECTORIES

It is not unethical for a physician to authorize the listing of his name and practice in a directory for professional or lay use which is intended to list all physicians in the community on a uniform and nondiscriminatory basis. The listing shall not include any self-aggrandizing statement or qualitative judgment regarding the physician's skills or competence. The *American Medical Directory* provides an example of the kind of information that may be properly listed in national as well as community directories for health service personnel. Likewise, specialties or specialty practices used in the *American Medical Directory* should set the pattern for specialty designations.

ADOPTED BY THE HOUSE OF DELEGATES,
DECEMBER, 1974

CX 717

May 29, 1975 letter from Bruce Nortell to Larry S. Boress

[2093] May 29, 1975

Larry S. Boress
Illinois State Medical Society
55 East Monroe Street
Chicago, Illinois 60603

Dear Mr. Boress:

Your letter of May 21, 1975 has been referred to me for reply. You asked for information on a booklet for county medical societies interested in creating health resource directories for their communities.

While the use of such a directory is not, in and of itself, unethical, it is fraught with difficulties and cannot be casually endorsed. Because of these difficulties, I think a medical society should be most cautious in formulating such a directory. As the Judicial Council has indicated, the commentary on such directories is more negative than positive, *i.e.*, "it is not unethical to. . . ."

It seems strange that a physician may state in a directory such things as continuing medical education courses he has taken, but that such information would be considered unethical if found on his letterhead. The difficulty in the dissemination of such information would be compounded, as well, by the potentially greater distribution that a directory would probably receive.

I counted approximately 28 places in the proposed publication that I think might present difficulties. For example, as a practical matter, if nothing else, I think a physician would be foolish to provide information to a directory phone survey. The potential for abuse by an unknown non-approved surveyor is enormous. Forma-

tive statements on the advantages of group versus solo practice are also dangerous generalizations, since "exceptions" may be prevalent. There is even a question in the Questionnaire that, in effect, requires the respondent to indicate whether his conduct conforms to certain ethical principles that have been enunciated by the Judicial Council. I am sure it was not the intent of this proposed publication to raise such problems. Unfortunately, this can be the effect when it is attempted to quantity such ultimately subjective qualities.

As a legal precaution, I would recommend that, if this publication is to be distributed, it be reviewed by the state society's own attorney. I think, for instance, that it may be misleading to suggest that such diverse
[2094] groups as the AMA, Consumers Union, and *Medical* Economics "contributed" to the publication. For its part, the AMA is *not* on record as positively favoring directories nor does it regard them as inevitable as the coming of "' the sea.'" I am also afraid that any such detailed directory as your publication suggests could not help but be self-aggrandizing for certain physicians, contrary to AMA principles.

In closing, I know this letter must seem harsh and critical. I hope, however, that you will appreciate the difficulties involved in evaluating such publications. I am sure the state society is trying to act to benefit consumers. The use of such a detailed publication, though, may be more detrimental than beneficial. If you would like to discuss this matter in more detail, please feel free to call me.

Very truly yours,

Bruce Nortell
Assistant to Secretary
to Judicial Council

BN/cac

Excerpts from RX 1

Opinions and Reports of the Judicial Council

(1977 edition)

CAVEAT

This is the first comprehensive revision of *Opinions and Reports of the Judicial Council* since it was originally compiled in 1958. The Judicial Council decided to prepare this comprehensive revision in the fall of 1975. Subsequently, the Judicial Council suspended the distribution of the previous edition of *Opinions and Reports* and, after extensive discussion and several revisions, produced this edition for publication.

In the previous editions of *Opinions and Reports,* the subject matter was separated into eleven parts, consisting of the *Preamble* and each of the ten sections of the *Principles of Medical Ethics.* The subjects presented, however, did not always closely correspond with the particular *Principles* under which they were listed. Also, the subjects often embraced more than one section of the *Principles of Medical Ethics,* even though listed under only one section. Therefore, the format of *Opinions and Reports* has been changed so that it will now follow an outline based on subject matter.

The *Principles of Medical Ethics* are an expression of the AMA House of Delegates. *Opinions and Reports of the Judicial Council* remains a basic compilation of interpretations, opinions, and statements of the AMA Judicial Council which may be expanded, contracted, or modified from time to time to meet changing conditions of medical practice.

As originally complied and republished in subsequent editions of *Opinions and Reports,* a number of long-standing statements of the American Medical Association were incorporated without editing because of their historical sig-

nificance. Some statements were included even though they might be construed to be inconsistent with similar statements of a later date which were also presented.

In the present edition of *Opinions and Reports*, some new items are included, while other have been withdrawn. Editorial changes have been made to clarify and improve the language and to eliminate statements which might be construed to be inconsistent. Some items have been withdrawn because they did not adequately reflect current conditions of medical practice or legal requirements. Other items not included dealt with outmoded matters of medical etiquette which embraced admonitions that have long been unnecessary and were historical anachronisms for a current publication.

Since extensive changes have been made in style, format, and content, the Judicial Council encourages comments which can be considered in the preparation of future editions of *Opinions and Reports of the Judicial Council*.

JUDICIAL COUNCIL

1977

HISTORY

The earliest written code of ethical principles for medical practice was conceived by the Babylonians around 2500 B.C. That document, the Code of Hammurabi, was indeed a *code* of conduct, setting forth in considerable detail for that era of history the nature of conduct demanded of the physician. Today that code would be subject to criticism because it went into too much detail. It may be doubted that it could have continued as a practical document through the centuries because, as medical science and cultural patterns became more complex, it would have required one skilled in jurisprudence to codify and interpret the myriad situations covered by it.

The Oath of Hippocrates, a brief statement of principles, has come down through history as a living statement of ideals to be cherished by the physician. This Oath was conceived some time during the period of Grecian greatness, probably in the fifth century B.C. It protected rights of the patient and appealed to the inner and finer instincts of the physician without imposing sanctions or penalties on him. Other civilizations subsequently developed written principles, but the Oath of Hippocrates (Christianized in the tenth or eleventh century A.D. to eliminate reference to pagan gods) has remained in Western Civilization as an expression of ideal conduct for the physician.

The most significant contribution to ethical history subsequent to Hippocrates was made by Thomas Percival, a physician, philosopher, and writer, of Manchester, England. In 1803, he published his *Code of Medical Ethics*. His personality, his interest in sociological matters, his close association with the Manchester Infirmary, led to the preparation of a "scheme of professional conduct relative to hospitals and other charities," from which he drafted the code which bears his name.

After the first real meeting of the American Medical Association in Philadelphia in 1947, the two principal items of business were the establishment of a code of ethics and the creation of minimum requirements for medical education and training. Although the Medical Society of the State of New York and the Medico-Chirugical Society of Baltimore had formal written coles of medical ethics prior to this time, it is clear from the records and the preface to AMA's first adopted Code of Ethics that it was based on Percival's Code.

In general, the language and concepts of the original Code adopted by the Association in 1847 remained the same throughout the years. There were revisions, of course, which reflected the temper of the times and the eternal

quest to express basic concepts with clarity. Major revisions did occur in 1903, 1912, and 1947. In 1957, the language of the chapter dealing with compensation of physicians, contract practice, conditions of medical service, free choice of physician, and purveyal of medical services was redrafted.

In December, 1955, an attempt was made to distinguish medical ethics from matters of etiquette. A draft of a two-part code seeking to accomplish this was submitted to the House of Delegates at that time but was not accepted. This proposal was, in effect, a segregation of then existing statements, found in the *Principles*, into two categories. Little or no change was made in the language of the forty-eight sections of the *Principles*.

Subsequently, in June, 1956, a seemingly radical proposal was submitted to the House of Delegates for consideration. This proposal, a short version of the *Principles*, was discussed at the following session of the House in December, 1956, after having had wide publication and broad consideration among members of the medical profession. It was then laid over for final consideration at the June, 1957 meeting of the House of Delegates, at which meeting the short version was adopted.

The format of the *Principles* adopted in June, 1957 is a change from the format of the *Principles* promulgated by Percival in 1803 and accepted by the Association in 1847. Ten short sections, preceded by a preamble, "succinctly express the fundamental concepts embodied in the present [1955] Principles," according to the report of the Council on Constitution and Bylaws. That Council assured the House of Delegates in its June, 1957 report that "every basic principle has been preserved; on the other hand, as much as possible of the prolixity and ambiguity which in the past obstructed ready explanation, practical codification and particular selection of basic concepts has been eliminated."

CONTENTS

I. INTRODUCTION 9
1.00. Terminology
1.01. The Relation of Law and Ethics

II. HOSPITAL RELATIONS 11
2.00. Admission Fee
2.01. Assessments
2.02. Billing For Housestaff Services
2.15. Fee Splitting and Hospitals
2.30. Hospital Ownership by Physician
2.70. Surgical Assistant's Fee

III. INTERPROFESSIONAL RELATIONS 13
3.50. Nonscientific Practitioners and Physicians
3.51. Optometry
3.60. Referral of Patients
3.70. Specialists
3.71. Teaching

IV. OFFICE PRACTICES 15
4.00. Appointment Charges
4.02. Clinics
4.03. Collection Agencies
4.04. Contingent Physician Fees
4.05. Contractual Relationships
4.15. Entertainment Expenses
4.16. Fees
4.30. Insurance Form Completion Charge
4.31. Interest Charges and Service Charges
4.40. Laboratory Services
4.41. Lien Laws
4.61. Professional Corporations
4.62. Records on Termination of Partnership
4.63. Restrictive Covenants
4.70. Sale or Purchase of Physician's Records

V. PATIENT RELATIONS AND MEDICAL RESPONSIBILITIES 20
5.00. Abortion
5.01. Artificial Insemination: Human
5.02. Clinical Investigation
5.03. Confidentiality: Attorney-Physician Relation
5.04. Confidentiality: Computers
5.05. Confidentiality: Drug Dispensing and Venereal Disease
5.06. Confidentiality: Insurance Company Representative
5.07. Consultation
5.15. Definition of Death
5.17. Euthanasia and Terminal Illness
5.18. Experimentation: Human
5.50. Neglect of Patient
5.51. Organ Transplantation Guidelines
5.60. Professional Courtesy
5.61. Records of Physicians: Availability of Information To Other Physicians
5.62. Records of Physicians: Information and Patients
5.63. Records of Physicians On Retirement
5.70. Substitution of Surgeon Without Patient's Knowledge or Consent
5.71. Unnecessary Services

VI. PUBLIC RESPONSIBILITIES 30
6.00. Advertising And Solicitation
6.01. Advertising, Solicitation, and HMOs
6.08. Civil Rights and Professional Responsibility
6.09. Communications Media: Press Relations
6.10. Communications Media: Public Figures
6.12. Communications Media: Standards of Professional Responsibility
6.15. Discipline and Medicine
6.16. Drugs and Devices: Prescribing
6.18. Due Process

6.20. Fee Splitting and Rebates
6.21. Fee Splitting: Billing
6.22. Fee Splitting: Clinics and Laboratories
6.24. Fee Splitting: Group Practice
6.25. Fee Splitting: Purchase of Medical Practice on Percentage Basis
6.26. Fee Splitting: Rentals
6.28. Free Choice
6.40. Local Medical Societies: Responsibilities
6.51. Nursing Home or Optical Dispensing Shop Ownership by Physicians
6.60. Patent For Surgical or Diagnostic Instrument
6.61. Peer Review
6.70. Secret Remedies

VII. APPENDIX 42
AMA Constitution and Bylaws: Judicial Council
Rules of the Judicial Council
Rules of the Judicial Council in Original Jurisdiction Cases
The Oath of Hippocrates
Declaration of Geneva

I. INTRODUCTION

1.00. *Terminology*

Historically, the term "ethical" has been used in opinions and reports of the Judicial Council and in resolutions adopted by the House of Delegates to refer to matters involving (1) moral principles or practices; (2) customs and usages of the medical profession; and (3) matters of policy not necessarily involving issues of morality in the practice of medicine. The term "unethical" has been used to refer to conduct which fails to conform to these professional standards, customs and usages, or policies, as interpreted by the American Medical Association.

Unethical conduct involving moral principles, values and duties calls for disciplinary action such as censure, suspension, or expulsion from medical society membership.

Failure to conform to the customs and usages of the medical profession may call for disciplinary action depending upon the particular circumstances involved, local attitudes, and how the conduct in question may reflect upon the dignity of and respect for the medical profession.

In matters strictly of a policy nature, a physician who disagrees with the position of the American Medical Association is entitled to freedom and protection of his point of view.

1.01. *The Relation of Law and Ethics*

The following statements are intended to clarify the interrelationship between law and ethics.

Ethical standards of professional conduct often exceed but are never less than those required by law.

Violation of governmental laws may subject the physician to civil or criminal liability. Expulsion from membership is the maximum penalty that may be imposed by a medical society upon a physician who violates ethical standards involving a breach of moral duty or principle. However,

medical societies have a civic and professional obligation to report to the appropriate governmental body or state board of medical examiners creditable evidence that may come to their attention involving the alleged criminal conduct of any physician relating to the practice of medicine.

Although, a physician charged with alleged illegal conduct may be acquitted or exonerated in civil or criminal proceedings, this does not discharge a medical society from its obligation to initiate a disciplinary proceeding against a member with reference to the same conduct where there is creditable evidence tending to establish unethical conduct.

Ethical pronouncements of the Judicial Council and the House of Delegates should not be so interpreted, construed or applied as to encourage conduct which violates a valid law.

IV. OFFICE PRACTICES

4.00. *Appointment Charges*

Charging for a missed appointment or for one not cancelled 24 hours in advance need not, in itself, be considered unethical if the patient is fully advised that the physician will make such a charge. The practice, however, should be resorted to infrequently and always with the utmost consideration of the patient and his circumstances.

4.02. *Clinics*

The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee, or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

4.03. *Collection Agencies*

The physician's ethical responsibilities in referring a delinquent account to a collection agency should include the following. He should first give due consideration to the patient's ability to pay the fee which is due. Secondly, he should not utilize the services of a collection agency whose tactics and methods of collection might be unfair or abusive. The physician may not "sell" his delinquent accounts to a collection agency and may not enter into any arrangement under which the physician would lose complete control of the delinquent account or the method of its collection.

4.04. *Contingent Physician Fees*

If a physician's fee for medical service is contingent on the successful outcome of a claim, there is the ever-present danger that the physician may become less of a healer and more of an advocate. Accordingly, a physician's fee for medical services should be based on the value of the service provided by the physician to the patient and not on the uncertain outcome of a contingency that does not in any way relate to the value of the medical service.

4.05. *Contractual Relationships*

The contractual relationships that physicians assume when they enter prepaid group practice plans are varied. Income arrangements may include hourly wages for physicians working part time, annual salaries for those working full time, and share of group income for physicians who are partners in groups that are somewhat autonomous and contract with plans to provide the required medical care. Arrangements also usually include a range of fringe benefits, such as paid vacations, insurance and pension plans.

Physicians may work directly for plans or may be employed by the medical group or the hospital that has contracted with the plan to provide services. The AMA recog-

nizes that under proper legal authority such plans may be established and that a physician may be employed by, or otherwise serve, a medical care plan without violating the Principles of Medical Ethics. It believes that in the operation of such plans physicians should not be subjected to lay interference on professional matters and that their primary responsibility should be to the patients they serve.

4.15. *Entertainment Expenses*

Expenditures made by physicians for the entertainment of other physicians are not per se unethical. There are circumstances in which a physician may appropriately entertain other physicians. The propriety of such matters must be determined on a case-by-case basis.

4.16. *Fees*

The charging of an excessive fee is unethical and is contrary to Section 7 of the Principles. The physician's fee should be commensurate with the services rendered and the patient's ability to pay.

4.30. *Insurance Form Completion Charge*

The attending physician should complete without charge the appropriate "simplified" Health Insurance Council forms and similar insurance claim forms as a part of his service to the patient to enable the patient to receive his benefits.

A charge for more complex forms may be made in conformity with local custom. This suggestion is advisory. In all cases, the local medical society can be looked to for an authoritative opinion.

4.31. *Interest Charges and Service Charges*

It is not in the best interest of the public or the profession to charge interest on an unpaid bill or note, or to charge a penalty on fees for professional services not paid within a prescribed period of time, or to charge a patient

a flat collection fee if it becomes necessary to refer the account to an agency for collection.

It is not improper, however, for a physician to add a service charge, equal to the actual administrative cost of rebilling, on accounts not paid within a reasonable time. The patient must be notified in advance of the existence of this practice.

VI. PUBLIC RESPONSIBILITIES

6.00. *Advertising and Solicitation*

This statement reaffirms the long-standing policy of the Judicial Council on advertising and solicitation by physicians. The Principles of Medical Ethics are intended to discourage abusive practices that exploit patients and the public and interfere with freedom in making an informed choice of physicians and free competition among physicians.

Advertising.—The Principles do not proscribe advertising; they proscribe the solicitation of patients. Advertising means the action of making information or intention known to the public. The public is entitled to know the names of physicians, the type of their practices, the location of their offices, their office hours, and other useful information that will enable people to make a more informed choice of physician.

The physician may furnish this information through the accepted local media for advertising or communication, which are open to all physicians on like conditions. Office signs, professional cards, dignified announcements, telephone directory listings, and reputable directories are examples of acceptable media for making information available to the public.

A physician may give biographical and other relevant data for listing in a reputable directory. A directory is not reputable if its contents are false, misleading, or deceptive or if it is promoted through fraud or misrepresentation. If the physician, at his option, chooses to supply fee infor-

mation, the published data may include his charge for a standard office visit or his fee or range of fees for specific types of services, provided disclosure is made of the variable and other pertinent factors affecting the amount of the fee specified. The published data may include other relevant facts about the physician, but false, misleading, or deceptive statements or claims should be avoided.

Local, state, or specialty medical associations, as autonomous organizations, may have ethical restrictions on advertising, solicitation of patients, or other professional conduct of physicians that exceed the Principles of Medical Ethics. Furthermore, specific legal restrictions on advertising or solicitation of patients exist in the medical licensure laws of at least 34 states. Other states provide regulation through statutory authority to impose penalties for unprofessional conduct.

Solicitation.—The term "solicitation" in the Principles means the attempt to obtain patients by persuasion or influence, using statements or claims that (1) contain testimonials, (2) are intended or likely to create inflated or unjustified expectations of favorable results, (3) are self-laudatory and imply that the physician has skills superior to other physicians engaged in his field or specialty of practice, or (4) contain incorrect or incomplete facts, or representations or implications that are likely to cause the average person to misunderstand or be deceived.

Competition.—Some competitive practices accepted in ordinary commercial and industrial enterprises—where profit-making is the primary objective—are inappropriate among physicians. Commercial enterprises, for example, are free to solicit business by paying commissions. They have no duty to lower prices to the poor. Commercial enterprises are generally free to engage in advertising "puffery," to be boldly self-laudatory in making claims of superiority, and to emphasize favorable features without disclosing unfavorable information.

Physicians, by contrast, have an ethical duty to subordinate financial reward to social responsibility. A physician should not engage in practices for pecuniary gain that interfere with his medical judgment and skill or cause a deterioration of the quality of medical care. Ability to pay should be considered in reducing fees, and excessive fees are unethical.

Physicians should not pay commissions or rebates or give kickbacks for the referral of patients. Likewise, they should not make extravagant claims or proclaim extraordinary skills. Such practices, however common they may be in the commercial world, are unethical in the practice of medicine because they are injurious to the public.

Freedom of choice of physician and free competition among physicians are prerequisites of optimal medical care. The Principles of Medical Ethics are intended to curtail abusive practices that impinge on these freedoms and exploit patients and the public.

6.01. *Advertising, Solicitation, and HMOs*

It is not unethical for a physician to provide medical services to members of a prepaid medical care plan or to members of a health maintenance organization which seeks members (or subscribers) through advertising its services, facilities, charges, or other non-professional aspects of its operation as long as such advertising does not identify, refer to, or make any qualitative judgment concerning any physician who provides service to the members or subscribers.

The foregoing qualification is intended to discourage deceptive advertising which would lead prospective members (or subscribers) to believe that the services of a named physician who has a reputation for outstanding skill would

be routinely available to all members (or subscribers) having need for his kind of services if in fact this is not so. However, the publication by name of the roster of physicians who provide services to members, the type of practice in which each is engaged, biographical and other relevant information as outlined in 6.00 above is not a deceptive practice.

6.08. *Civil Rights and Professional Responsibility*

The American Medical Association is in favor of equality of opportunity in medical society activities, medical education and training, employment, and all other aspects of medical professional endeavors regardless of race, color, religion, creed, ethnic affiliation, national origin, or sex.

The American Medical Association is unalterably opposed to the denial of membership privileges and responsibilities in county medical societies and state medical associations to any duly licensed physician because of race, color, religion, creed, ethnic affiliation, national origin, or sex.

The American Medical Association calls upon all state medical associations, all component societies, and all individual members of the American Medical Association to exert every effort to end any instance in which such equal rights, privileges, or responsibilities are denied.

• • • • •

6.26. *Fee Splitting: Rentals*

An arrangement by virtue of which a physician leases office space for a percentage of gross income is not acceptable; it is violative of ethical principles. The practice indirectly results in fee splitting and tends to exploit the practice of medicine. If the size of a physician's practice increases and imposes additional demands on the facilities of the building, these facts may be considered when the time comes to renegotiate the rental value of the leased

premises, and a new fixed rental, taking these items into account, might be agreed upon.

The rental of space by a physician or group of physicians as a pharmacy should be a fixed one. Were the rental to be based on the amount of business, it might well be argued, and indeed be the case, that fee splitting existed. In addition, the temptation would be ever present for the physician-owner to encourage patients to take their prescriptions to that pharmacy. The evils inherent in such practice are too obvious to be mentioned.

6.28. *Free Choice*

Free choice of physicians is the right of very individual. The individual may select and change at will the physicians who serve him, or he may choose a medical care plan such as that provided by a closed panel or group practice, or he may choose to obtain medical care by becoming a subscriber of a health maintenance or service organization. The freedom of the individual to select his preferred system of medical care and free competition among physicians and alternative systems of medical care are prerequisites of ethical practice and optimal medical care.

6.40. *Local Medical Societies: Responsibilities*

The county society is autonomous. Local or state medical associations, as autonomous organizations, may have ethical restrictions on professional conduct of physicians that exceed the Principles of Medical Ethics of the American Medical Association. Ethical standards of professional conduct may also exceed but are never less than those required by law. Such autonomy imposes responsibilities. If medical societies fail to accept and discharge their obligations in matters of ethics, others will assume these obligations by default.

Excerpt of Testimony of C. H. William Ruhe, M.D.—Tr. 5182-85

[5182] Q. What place do these programs that have been described as medical education and scientific affairs and scientific publications have in the priorities of the American Medical Association?

MR. COSTILO: Objection. I think that that question is too general and ambiguous as to its place.

[5183] JUDGE BARNES: I assume your organization has priorities and this seems to be an appropriate question.

You may answer it.

THE WITNESS: These programs have a very high priority as I view it. Obviously, my position as senior vice president in these areas—these are the areas I am responsible for. They are, in fact, the heart and sole of our activities. They are the heart and sole of our organization. They constitute and from the very beginning the primary reason for the existence of the organization.

And the fact that they continue to be so is evidenced by the amount of finances put into them regularly. Our budgetary system is set up on a programatic basis and it is according to missions and programs and projects. It is a little difficult to dissect out the separate portions of all the activities and to rearrange them according to their classification. But my best estimate would be that about two-thirds of the expenditures of the AMA goes to support these kinds of activities, medical education, scientific activities and scientific publications. I think that is the bottom line of the evidence on priority positions on which the Association places these acti-

[5184] vities.

By Mr. Bierig:

Q. Well, you have characterized these activities as the heart and sole of the American Medical Association. Doctor Ruhe, what about membership retirement plans any any insurance programs that might be available to members of the American Medical Association?

A. Well, it is certainly true that we do have programs for benefits of the membership. We are a large organization. We have substantial dues which members pay. We believe we have some obligations to the membership also particularly in assisting them to have benefits of this sort of life insurance benefits, retirement benefits.

But these are not the basic operations of the organization. As a matter of fact, they are a relatively recent activity in the organization in terms of long range functions and programs of the organization. They have come along really quite recently.

The basic operations continue to be the educational and scientific activities. These other things are embellishments which I don't see anything particularly wrong with that, but having benefits for its members of
[5185] the organization. But that is not the purpose of the organization and that is not why it was established. That is not what makes it run today.

Q. No further questions of this witness.

RX743—Sturdivant et al., "Comparative Analysis of the American Medical Association Versus Other Associations" (1977)

Comparative Analysis of the AMERICAN MEDICAL ASSOCIATION Versus Other Associations

Prepared for the
AMERICAN MEDICAL ASSOCIATION
by

Frederick D. Sturdivant
John C. Kirby
Michael J. Hobor

Management Analysis Center, Inc.

December 7, 1977

TABLE OF CONTENTS

Introduction 1

Part

I: Analysis of AMA's Budget (1977) 5

II: Comparative Operating Ratio Analysis 10

III: Comparative Cultural Analysis 18

IV: Conclusion 27

Appendix

I: Pie Graph of AMA 1977 Budget

II: Classification of AMA 1977 Project Budgets

III: Notes on the Use of the ASAE Report

IV: Comparative Operating Ratio Income and Expense Graphs

V: List of Interviews with Non-AMA Association Officials

VI: List of Interviews with AMA Officials

VII: List of Printed Works Cited and Other Sources

VIII: Biographies of Report Staff

INTRODUCTION

The purpose of this study was to determine whether or not the American Medical Association is organized and operated for its own profit or that of its members. To arrive at an answer to this question, an analysis was undertaken along three dimensions. First, a careful and independent study of the Association's budget was conducted, since the critical determinant of the nature of an organization is the allocation of its resources. Expenditures and their related activities were assigned to categories based on their relationship to the economic benefit to members.

Second, in order to place the AMA's budget and resource allocation process in a broader context, a comparative analysis was undertaken involving the use of a data base consisting of the budgets of over 1,000 associations. These data were contained in the *Association Operating Ratio Report: 1977*, compiled by Touche Ross & Company for the American Society of Association Executives (ASAE). The purpose of this comparative analysis was to profile the American Medical Association's income and expenditures versus those of various *types* of associations such as manufacturing and educational to determine if the AMA more closely resembled profit or non-profit-oriented associations.

Third, a largely non-financial, "cultural" comparison was made of the AMA versus six other associations on the basis of criteria which are indicative of an organization's profit or non-profit orientation. These criteria were drawn, in part, from the National Commission on Egg Nutrition case and included such variables as origin, character of membership, and nature of publications.

An objective assessment of all three of these analyses—even allowing for a rather broad interpretation of the concept of economic benefit—leads to the conclusion that the AMA is neither organized nor operated for the profit of itself or its members. The American Medical Association is

a professional association engaged overwhelmingly in scientific and educational activities.

Before turning to the three analyses, it may be useful to review briefly certain background and definitional materials. They are designed to establish the historical context in which the AMA began and to provide working definitions to profit, economic benefit, and profession.

Examination of the earliest printed history of the American Medical Association, N. S. Davis' History of the *American Medical Association from Its Organization up to January, 1855* (Philadelphia, 1855) leaves no doubt that medical education was the impetus for its founding. As a leading member of the opening convention in 1847 later put it:[1]

> The great leading object, the fundamental idea, which impelled the formation of our great national organization, was the improvement of the system of MEDICAL EDUCATION, and consequently, the elevation of the whole profession.

The Association's establishment bisects the history of American medical education. Before the AMA, there was no national organization in the U.S. to encourage or even report on, much less enforce, quality in American medical education. There was no uniformly agreed upon curriculum, no independent or impartial examination of medical educators, no graduate medical education, and, most importantly, no examination for medical licenture except by medical school professors who were paid per capital based on the number of students they graduated. Medical schools scattered throughout the various states competed for students largely be shortening the length of their school year.[2] Be-

---

[1] Davis, p. 135. The italics are original.

[2] *Ibid.*, p. 19. Also see William Frederick Norwood, *Medical Education in the United States before the Civil War* (Philadelphia, University of Pennsylvania Press, 1944). This work is cited as authoritative by the Library of Congress, General Reference and Bibliography Division and Reference Department, *A Guide to the*

tween 1830 and 1845 alone, the number of such schools doubled.[1] By 1846, the year before the Association's founding, it was possible to become a "doctor" after only 39 weeks of study.[2]

Separating teaching from licenture to increase the impartiality of examinations was a chief early goal of the AMA, as was the establishment of a rational and uniform curriculum. Other early efforts focused on encouraging the passage of "uniform and efficient laws for the registration of births, marriages, and deaths," on creating "a general Nomenclature of Diseases," on "Preliminary Education," and on "Medical Ethics."[3]

In order to determine whether the AMA's educational purposes were later transformed into profit objectives, it was necessary to review the meaning of the terms "profit" and "economic benefit." The operating definition of profit used in this analysis restricts that term to its traditional economic meaning: the sum remaining after all costs, direct and indirect, are deducted from income. From the standpoint of this report, the phrase "economic benefit" is utilized

---

Study of the United States of America (United States Government Printing Office: Washington, D. C., 1960), item 4860 at page 663:

> During the first half of the new [19th] century an increasing population and a continuous westward migration crested a growing demand for doctors and so for medical schools. These sprang up without regulation, and often only for the financial gain of the promoters. Largely in order to improve the standards of the medical schools the American Medical Association was organized by leaders of the profession in 1847.

[1] Davis, p. 19. For a substantiation of Davis' figures, see U.S. Department of Commerce, Bureau of the Census, *Historical Statistics of the United States: Colonial Times to 1957* (U.S. Government Printing Office: Washington, D.C., 1960), p. 34, Series B-186.

[2] Davis, p. 19.

[3] Davis, pp. 41, 42.

to identify benefits of an economic nature which can accrue from membership in an organization but which do not fall within the definition of profit. Examples are insurance, retirement programs, and improved negotiating skills.

Finally, the word "profession" as used in this report connotes the standard definition of modern English usage as given in the *Oxford English Dictionary*:[1]

PART I: Analysis of the AMA Budget, 1977

The character of an organization is best revealed by an examination of how it allocates its resources. Resource allocation in turn is reflected in the organization's budget. Consequently, an analysis was undertaken of the 1977 AMA budget to determine whether the AMA devotes its resources to returning a profit for itself or its members. The fiscal year 1977 was chosen because it is the most recent year for which figures are available.

Our analysis of the AMA's 1977 budget was taken directly from 309 project request form approved that year. Each project sheet contained a title for the project, a description of the project, and the dollar amount allocated in the budget. These sheets were reviewed separately by the researchers and placed into one of four major categories. These judgments were made independently by the researchers and

---

[1] The oldest use of the word in this context appears in Robert Copland, *The questyonary of ayrurgyens* (1541-42):

> The parties of the art of Medycyne can not be separated one from the other without dommage and great detryment of all the medicynall professyon. [Original spelling retained]

> The occupation which one professes to be skilled in and to follow. A vocation in which a professed knowledge of some department of learning or science is used in its application to the affairs of others or in the practice of an art founded upon it. Applied specifically to the three learned professions of divinity, law, and medicine; also to the military profession.

without guidance from anyone affiliated with the AMA. The categories are:

A. Educational, Scientific, and Association Maintenance
B. Indirect Economic Benefit
C. Direct Economic Benefit
D. Miscellaneous

As the titles of the categories suggest, an attempt was made to differentiate between those activities of the Association which offer economic benefit to its members and those that do not. Loosely construed, economic benefit may be found in virtually any activity of an organization. Thus even a charitable contribution might be seen as an effort to improve the image or reputation of an organization and its members. However, conclusions of this type are speculative in nature and are dependent upon the always difficult interpretation of motives. We chose instead to screen projects on the basis of the following objective criteria:

Does the project assist the profession in:

- the acquisition of knowledge
- the dissemination of knowledge
- the certification that knowledge has been correctly taught and mastered
- the delivery of medical services
- the presentation of the profession's views on issues related to the practice of medicine and public health
- the maintenance of the association.

Activities failing to pass this screen would be those offering an economic benefit to physicians, either directly or indirectly. The projects placed in Class B, for example, all seem to provide an indirect economic benefit to physicians, whether or not they are AMA members, by increasing the managerial and other skills of non-physicians who aid and assist physicians, by aiding local medical societies, or by providing data of a business sort. Class C projects suggest a more direct economic benefit to physicians because these

projects directly train the physicians themselves in managerial skills or provide them with benefits such as insurance or retirement programs.

Perhaps a final distinction needs to be made. Attending an AMA conference or subscribing to *JAMA* were seen as activities on the part of physicians which contributed to professional growth. Only incidentally are such activities related to economic benefit (as was the case with the charitable gift by an organization).

Category A was divided into eight sub-categories, as follows:

A_1: Lay Public Education
A_2: Journals and Scientific Publications
A_3: Scientific Policy
A_4: Other Scientific
A_5: Data on Physicians and Health Care
A_6: Medical Quality Control and Education
A_7: Government Interface
A_8: Organizational Maintenance and Operations

This categorization produced the results displayed in Table 1. Thus, the vast majority of the AMA's resources in 1977 were directed toward educational and scientific concerns and the delivery of medical services. Together these project types (A_1 through A_7) account for 66.5 percent of the Association's budget. The necessary and typical kinds of activities needed to maintain and service any large association (A_8) account for an additional 25.8 percent of the Association's budget. Consequently, a total of 92.3 percent of the Association's budget went toward non-commercial activities rather than any kind of profit-making ventures on the part of the Association on its own behalf or for its members. One must conclude that the AMA acted fundamentally as an educational organization involved in the basic activities of a scientific profession.

Table 1: AMA Budget Allocations in 1977*

Program Category	# of Projects	$	%
A_1	24	2,028,220	4.5
A_2	22	13,009,612	28.9
A_3	18	977,526	2.2
A_4	15	935,760	2.1
A_5	43	3,815,005	8.5
A_6	78	7,452,916	16.6
A_7	11	1,650,410	3.7
A_8	73	11,608,265	25.8
A Total	284	41,477,714	92.3
B	6	496,705	1.1
C	13	1,499,750	3.3
D	6	1,507,517	3.4
Grand Total	309†	44,981,686†	100.1

*See Appendix I for a pie diagram of the same data. See Appendix II for the name and cost of each project in each category.

† After this analysis was completed it was learned that nine projects totalling $1,220,033 had not been included in the original data package supplied to the research team. Two of the projects accounted for 88.8 percent of the total. They were "(PA) Commissions-Dues Collections" $361,411 and "(PD) List House Activities" $722,695. Based on descriptions provided by Robert Herbst of the AMA during a telephone conversation, it would appear that the first project should be classified as an A_8 and the second as a B. If the latter is added to the B category that group of projects becomes 2.6 percent of a total budget of $46,201,719. The balance of the nine projects would have an almost imperceptible effect on the percentage resource allocation regardless of how they were classified. Those projects are as follows:

JA	AMA Exhibits	$13,858
JC	Provide Information to Physicians on Mental Retardation	11,988
NA	M.D.'s Wife	2,951
NA	AMA Member's Bond Fund	2,674
NB	American Association of Medical Society Executives	89,772
PA	AMA Real Estate Investments	45,310
JB	Pamphlets	(30,626)

This conclusion is reinforced by the fact that the projects classified as having an indirect benefit to physicians represented only 1.1 percent of the Association's activities.[1] The third category (C) in which direct economic benefits could be traced to physicians represented 3.3 percent of the 1977 AMA budget.

The projects in Category D were harder to classify. Totalling 3.4 percent of the budget, they are activities that could conceivably fall into two or more categories. Only five projects are in this group. Typical is the *Medical Staff Advocate Newsletter* sent to hospital medical employees (AMA members or not) reporting on topics of interest. This activity could be classified as membership promotion (A_8), medical service delivery (A_5), or direct economic benefit (C) if one assumes that it somehow helped medical staffs better their economic status. A more critical example of type D is AMA services to AMPAC, since it could be argued that some of AMPAC's activities might accrue to the economic benefit of physicians and thus by classified as type B or C. On the other hand, AMPAC's activities might be classified as A_7, since its principal function is to encourage AMA members and their spouses to become involved in the political process and to generate financial support for candidates. In any case, D totals only 3.4 percent of the Association's budget.

PART II: Comparative Operating Analysis

The preceding analysis explored the results of the internal AMA resource allocation process to assess the nature of that organization. This section of the report places the results of that resource allocation process in a broader context and adds the dimension of income sources. The ob-

[1] The reader is reminded that the new information on nine budget items would appear to increase the relative importance of Category B from 1.1 percent to 2.6 percent.

jective of this analysis was to compare the AMA's income and expense profile with that of various types of associations to determine if it more closely resembles profit-oriented or non-profit-oriented associations. Therefore, while a number of association types are represented in Appendix IV, it is probably most instructive to compare the AMA's profile with that of Corporate Manufacturing (profit) and Individual Educational (non-profit).

The most recent and comprehensive study of association financing and activities is the *Association Operating Ratio Report: 1977*, compiled by Touche Ross & Company for the American Society of Association Executives (ASAE). The data base is in excess of 1,000 associations and was collected between August 1976 and January 1977 using the most recently completed financial year in each case. For the AMA that was 1975, a year in which its budget totalled $37,300,000. Touche Ross received the data and personally contacted respondents "to reconcile questionable data where required."[1] The AMA data used here, taken directly from

[1] Touche Ross did not audit the information. However, the questionnaire supplied reasonably precise definitions for each income and expense category. As is often the case with collecting data from a number of organizations for purposes of aggregation, however, interpretation of definitions did vary somewhat. AMA, for example, reported that its Executive and Administrative expenses came to $1,100,000, or 2.9 percent. In fact, it probably would have been more accurate to have reported additional indirect costs of $8,100,000 which were actually budgeted for General and Administrative expenses ($5.7 million) and occupancy ($2.4 million) that year. That amount represented 21.7 percent of the AMA budget in 1975. As a result, that category of expenses was understated and all others were overstated. Appendix III graphs treating expenses, therefore, show two bars for each category for the AMA. The first reflects the data reported originally by the AMA, and the second has been adjusted by a factor of 24.6 percent (21.7 percent + 2.9 percent). All expense figures in the text refer to adjusted members because they are believed by the authors to be more accurate.

a photocopy of the original questionnaire the AMA returned to Touche Ross, were supplied to us by Touche Ross.

The ASAE report divides associations into corporate membership and individual membership types. Within these large categories, sub-types are also defined.[1] For the purposes of analysis, this report compares the AMA with the following types of associations defined in the ASAE report:[2]

- All Associations with Corporate Membership
- All Associations with Individual Membership
- Corporate Member Associations in the Manufacturing Industry
- Corporate Member Associations in Health Care
- Individual Member Associations in Legal Professions
- Individual Member Associations in Medical Professions (Note: The AMA is itself included in this category.)
- Individual Member Associations in Educational Professions

These eight categories, including the AMA, were compared using 25 variables, every income source, and every functional expense source defined by the ASAE study. The result shows the AMA to be unusual in almost every case.[3]

Taking the fifteen income source variables first, the AMA is lowest in the percent of its income derived from dues, both regular and associate (39.1 percent), while Corporate Manufacturing is highest (65.6 percent). The very modest

---

[1] Geographic and budget size categories are defined as well but considered irrelevant for the purposes of this study.

[2] See Appendix III for definitions of the groupings and the rationale behind their choice. Material drawn from Tables 7, 8, 9, 12, 17, 18, 19.

[3] See Appendix IV for comparative bar graphs of both income and expense.

cost the AMA charges for its educational programs makes that the lowest percentage for that source as well (1.5 percent). Its investment income is also the lowest (1.5 percent), as is its income from newsstand journal sales (1.5 percent). AMA grant income is about average for all associations (3.7 percent), as is its modest income from certification, accreditation, and similar services (1.1 percent).

These relatively low sources are offset by others which are extreme at the other end of the scale. Reflecting a series of special assessments begun some years earlier and slowly tapering off, AMA income from special payments (18.2 percent) was more than 14 percentage points higher than that of any group of associations profiled. Subscription journal sales income was also the highest (7.5 percent), and some 2 percentage points over the nearest comparative group, Individual Membership Associations. Reflecting the fact that the AMA publishes ten scientific journals plus other periodicals, AMA advertising revenues (18 percent) are substantially higher than the nearest comparative group, Individual Member Associations in the Educational Professions (5.7 percent). Since most educational associations publish only one or two journals, if the AMA's advertising revenue is adjusted for the number of journals, the percent of income per journal is quite modest. AMA revenue from insurance programs (1.5 percent), while modest, is the second highest after Corporate Associations (3.2 percent). It represents the AMA's earnings from the Keogh plan offered to members. Unlike many associations, the AMA realized no revenues from meetings and conventions or exhibitions. AMA miscellaneous income (6.2 percent) was largely from royalties.

The general picture is that AMA revenues are much more related to journals than is the case with most associations. Advertising revenues in particular are higher, suggesting

that advertisers see AMA members as individual decision-makers whose views regarding the prescription of pharmaceuticals, for example, are critical to the sales success of their producers. It should be noted that the AMA strictly limits advertising in its ten scientific journals to products and/or services related to the practice of medicine[1] and that revenues from advertising are devoted to supporting other educational and scientific projects undertaken by the AMA. Indeed, surpluses from some of the journals are used to make up deficits on other journals are used to make up deficits on other journals which continue to be published in spite of their losses.

The large size of special assessment revenues was a temporary phenomenon brought about by an extraordinary and successful attempt to obviate a very serious financial weakness suffered by the Association in the early 70's. The low revenue from educational programs reflects a policy decision to make cost to participants (members and non-members) as small as possible to encourage physicians to keep current with new and improved medical techniques. While relative magnitude of income sources is of interest, the most critical dimensions of association income are whether those funds come principally from profit making groups *and* whether such groups exercise control over the association. As FTC Commissioner Dixon wrote in his opinion regarding the National Commission on Egg Nutrition, "this case presents far more than the example of an industry choosing to accord a measure of financial support to an otherwise unrelated third party whose views, when published, inure to the industry's benefit. Rather, respondent NCEN was founded and almost entirely funded by the egg industry, with the obvious expectation that it

[1] American Medical Association, *Principles Governing Advertising in Publications of the American Medical Association.*

would help counteract economically damaging publicity."[1] This aspect of funding will be treated more fully in the next section. Suffice it to say at this point that the AMA is neither dependent upon profit-making organizations for funding, nor has it sacrificed its autonomy to any such group.

As was the case in reviewing the AMA budget, the operating ratio analysis is more revealing when *expenditures* are considered. Again, resource allocations provided an important measure of the nature of an organization, and thus a comparison of the AMA with profit and non-profit-oriented groups provides insight. It is important to keep in mind that the objective of this analysis is to compare the AMA with profit versus non-profit associations. Again, Corporate Manufacturing and Individual Educational serve these two purposes quite well.

The ratio analysis report identifies nine expenses by function. The first of these, Executive and Administrative, reveals that the AMA expended 24.6 percent of its annual budget on that function versus 43.7 percent for Corporate Manufacturing and 31.3 percent for Individual Educational (see Appendix IV for bar charts for each of these expense categories).[2] While the AMA was the lowest of any group studied, it should be noted that Corporate Associations was the highest (45.6 percent).

The AMA's 9.7 percent expenditure for membership was higher than any other group (profit or non-profit) reported in Appendix IV. Corporate Manufacturing was 5.9 percent and Individual Educational was 7.8 percent. High expenses incurred for membership promotion suggest the Association

---

[1] *FTC Complaints and Orders* (New York: Commerce Clearing House, 1976), 21, 184.

[2] The reader is referred to footnote 1 on page 11 for an explanation of the figures used for the AMA.

has a hard time convincing physicians of the utility of joining, since most of the benefits are intangible. Most activities, such as educational programs, are open to all physicians, and any interested person can purchase the journals. Most of the advantages can be obtained, therefore, without paying dues. It would appear that Corporate Associations have less difficulty convincing firms of the utility of membership.

In the next two categories, public relations and government relations, the AMA's expenditure levels more closely resemble Corporate Association behavior than Individual Associations. The AMA expended 6.9 percent of its funds in each of these categories. Corporate Manufacturing averaged 9.5 percent for public relations and 3.1 percent for government relations. Comparable numbers for Individual Educational were 2.5 percent and 0.9 percent. These relative expenditure levels are probably best understood in light of the AMA's long-standing commitment to disseminate the views of physicians beyond their colleagues to the general public. Political interest in the practice of medicine has increased dramatically in recent years. Thousands of bills and proposals are offered annually. Doctors believe they have a traditional ethical responsibility for safeguarding the public health. Thus, as the number of proposals increases so does the burden on the medical profession to advise, consult, and disseminate information. As the government increases and deepens its interest, the medical profession increases and proliferates its advice, counsel, and warnings. It is also important to note that most of the Association's government and public relations activities are public health-oriented.

It is perhaps in the area of expenditures for publications that the contrasts between non-profit and profit-oriented associations are most distinct. The AMA expends 24 per-

cent on publications versus 10.6 percent for Corporate Manufacturing. The percentage for Individual Educational Associations is 21.4 percent. The centrality of scientific journals to the purpose of professional-scientific associations is clearly revealed in such figures. While commercial trade associations publish newsletters, trade journals, and the like, the character of these publications and their relative importance to the association differ in *kind* from professional-scientific associations.

The differences in the essential purpose of profit versus non-profit associations is further revealed in relative expenditures for educational programs. While Individual Educational Associations and the AMA spent 8.5 percent and 13.9 percent respectively for such purposes, Corporate Manufacturing averaged 3.7 percent. Again, the mission of disseminating knowledge is central to one and peripheral to the other. Expenditures for *non-educational* conventions and meetings accounted for only 2 percent of the AMA's 1975 budget versus 10 percent for Corporate Manufacturing. For reasons which are not clear, Individual Educational expenditures for that purpose were higher yet, 13.3 percent.

In the area of certification, accreditation, and standardization, the AMA expenditure level stood alone at 8.7 percent. Corporate Manufacturing and Individual Educational were 1.9 percent and 1.3 percent respectively. The large effort made in this area is directly related to the Association's traditional commitment to the development and maintenance of high quality standards in medical education.

These quality control efforts in medical education, when combined with the AMA's educational programs and publications, represent nearly half (46.6 percent) of the Association's expenditures. The same three categories for Corporate Manufacturing totalled 16.2 percent. For all Corporate Associations the total was 15.4 percent. Again,

the comparative resource allocation analysis argues strongly that the American Medical Association is an association engaged primarily in scientific-educational endeavors to improve medical science and public health. It is fundamentally different in character from commercial trade associations.

PART III: Comparative "Cultural" Analysis

While budgetary analysis can tell much about the fundamental character of an organization, there are a myriad of subtle attributes that financial figures cannot fully describe. We have elected to refer to the analysis in this section as cultural in nature because it probes the patterns of behavior, ideas, tools, and values of a set of associations. The specific salient characteristics which are explored are based largely on those used by Commissioner Dixon in his analysis of the National Council on Egg Nutrition. Thus the cultural analysis considers (1) origin, (2) character of membership, (3) source of funding and relationships with profit-making groups, (4) nature of publications, (5) stated purpose, and (6) accessibility to non-members.

The objective of this section is the same as in the earlier two parts, namely, to determine whether or not the AMA is essentially different in character than a profit-oriented trade association. In order to achieve this objective, this part of the paper compares the above salient characteristics of associations across an array of seven associations, the AMA and six others:

American Marketing Association
Association of American Geographers
American Association of University Professors
American Institute of Architects
Association of American Law Schools
Manufacturing Chemists Association

The associations were chosen to represent a variety of different types.[1] Thus the American Marketing Association has both academic and business members, with business members predominating, while the Association of American Geographers has both professional geographers and academics, with academics predominating. The American Association of University Professors is almost exclusively academic. The American Institute of Architects has both individual and firm memberships, and the Association of American Law Schools has as members the schools themselves, not individuals. The Manufacturing Chemists Association is a commercial trade association, and its members represent their firms. Personal interviews were conducted with each association.[2]

Throughout this analysis, the general criterion is a continuum from profit-making to non-profit institutions, with values assigned from 0 to 10. No value judgment is implied by the direction of the scale, which could, with equal validity and identical results, be reversed. Nor is it implied that the points assigned each association are additive, enabling the reader to calculate a total "score" by association. The approach taken in constructing the matrix of points is relatively common in the field of Social Indicators.[3] It is

[1] The six-association sample analyzed was chosen to provide a wide variety of the various types of American associations. It is thus not a random sample. Trade associations, in particular, are under-represented since most which were contacted refused to be interviewed. To safeguard against possible bias, the criteria to be evaluated were chosen before the associations to be analyzed were selected.

[2] See Appendix V for a list of persons interviewed and dates. See Appendix VI for a list of AMA officials interviewed.

[3] See, for example, Raymond A. Bauer (ed.), *Social Indicators* (Boston: MIT Press, 1966), and Eleanor B. Sheldon and Wilbert E. Moore (eds.), *Indicators of Social Change* (New York: Russell Sage Foundation, 1968).

designed to offer an overall, general profile which allows the reader to compare these seven associations with some reasonable degree of consistency and rigor. Its principal purpose, therefore, is to contrast the essential characteristics of profit versus non-profit-oriented associations.

Displayed in matrix form, the results were as follows:

	AMA	AAG	A.Mkt.A.	AAUP	AIA	AALS	MCA
1. Origin	10	10	10	10	10	10	0
2. Stated Purpose	10	10	10	10	5	10	0
3. Character of Membership	10	10	10	10	10	10	0
4. Nature of Publications	10	10	10	10	10	10	0
5. Sources of Funding and Relationship with Profit-Making Groups	10	10	10	10	10	10	0
6. Accessibility to Non-members	10	10	10	10	5	—	5

Where:

Origin refers to the perceived need which led to the founding of the association.

10 points if solution of a social problem or advancement of the common good with no profit accruing to the founders

5 points if attributable to both advancement of the common good and the enhancement of an industry's profit making capabilities

0 points if for the advancement and/or protection of a group's profit making capabilities

Since five of the six characteristics to be reviewed were drawn directly from the NCEN case, it may be useful to use Commissioner Dixon's opinion as a definitional base. In the NCEN opinion, he suggested that the NCEN was created as "a response by the egg industry to economically harmful attacks on the safety of eggs."[1] By contrast, it will

[1] This and all subsequent references to Commissoner Dixon's opinion will be drawn from *FTC Complaints and Orders* (New York: Commerce Clearing House, 1976), 21,090-21,091.

be recalled that in the introduction to this report the origins of the AMA were rooted in the need for an improved system of medical education. As indicated in the matrix, all of the associations studied with the exception of the Manufacturing Chemists Association (MCA) had non-profit origins.

Character of Membership distinguishes between the manner in which members are "selected."

10 points if the association's chief governing body has no designated or de facto seats for important industry members or firms

5 points if the association's chief governing body has de facto perpetual members

0 points if the association's chief governing body has de jure perpetual members

The NCEN opinion noted the failure of that association to separate its members' roles from their roles as agents of the egg industry. In general, professional, non-commercial associations are characterized by autonomy in governance based on widespread individual memberships. Of the seven associations surveyed, five had individual membership of some sort, and for four it was the only type of membership. The AIA has both individual and firm membership, the latter being a recent innovation to eliminate a free rider problem which allowed one member of a firm to join and secure membership advantages for the entire firm. By contrast, the Manufacturing Chemists Association has members who are representatives of the firms which employ them. It is impossible to be a member of MCA without belonging to a member firm, and association membership is terminated if the representative leaves the employment of his member firm. Furthermore, with the exception of the Manufacturing Chemists, all of the other associations surveyed did not have seats reserved on their chief governing body for particularly large or important members. MCA had over a half-dozen such seats.

Sources of Funding and Relationships with Profit-Oriented Groups refers to whether the association gets its funds from profit-making entities with an intent on reaping economic benefit and control of the association.

10 points if the association does not depend on profit-making organizations for its funding nor allow commercial objectives to control its policies and practices

5 points if the association receives approximately half of its funds from profit-oriented organizations and allows their commercial objectives to influence certain of the association's policies and practices

0 points if the association depends on profit-oriented organizations for its funding and has its policies and practices essentially controlled by its sponsors' commercial objectives

Although the distinction between sources of funding and relationships with profit-oriented groups was not altogether clear in the NECN opinion (hence they have been combined here), the implications for contrasting non-commercial associations and their profit-oriented counterparts would appear to be contained in the following quote from the opinion: "While the assertion of particular viewpoints may not be a contractual prerequisite to NCEN's receipt of funds, it is reasonable to doubt that NCEN could continue to exist if its Commissioners were somehow to reach and publicize the conclusion that consumption of eggs in quantity may possibly increase the risk of heart disease . . ." In a similar vein, MCA receives its support from member firms and strives to enhance their commercial objectives. As in the case of the NCEN, one could hardly expect the chemical manufacturing firms to fund an association which was totally objective and published reports critical of the industry or certain members.

The AMA and the other professional associations listed in the matrix are bound by no such strictures. They are not dependent on profit-making groups for their survival and

do not yield to their control. Their generally widespread membership base, coupled with the absence of controlling commercial interests, place them in sharp contrast to trade associations such as MCA and NCEN.

Nature of Publications refers to whether the association's publications represent a parochial, self-serving purpose for profit-oriented groups or if they are committed primarily to objective, scientific periodicals.

10 points if publications are primarily scientific and objective in nature
5 points if publications are evenly divided between scientific and trade journals
0 points if essentially all publications are trade oriented and lacking scientific objectivity

In the NCEN opinion, Commissioner Dixon wrote, "It is staffed by egg industry executives, originally required to be from a specified egg industry trade association and, predictably enough, its publications, whether they represent the 'industry' viewpoint or not, would encourage the consumption of eggs." Thus one of the most glaring differences between professional and commercial trade associations is in the nature of their periodical publications. Associations with professional and scholarly aims have journals that are regularly and carefully indexed, suggesting widespread agreement that the material in their pages is of long-term value. Indexing is expensive and seldom done for ephemeral materials ("eat more eggs"). The AMA is highly unusual because of the numbers of journals it publishes—a dozen, ten of which are scholarly journals of high repute. One of these, *JAMA*, is perhaps the nation's leading medical periodical and is translated for publication abroad. No other association surveyed had more than three journals, and none had more than two scholarly journals.[1] The publica-

[1] The 7,000-plus Post-Graduate Medical Education courses sponsored is equally extreme. No other association surveyed approaches this.

tions of all of the associations studied, with the exception of MCA, were indexed—a good surrogate measure of their lasting worth.

Stated Purpose is based on the association's official stated purpose.

10 points if it speaks solely about the improvement of the public good and/or advancement of art and/or science

5 points if, while speaking about the public good, it also specifically advocates the advancement of any profession or industry

0 points if it only advocates the advancement of a profession or industry.

"An early version of [NCEN's] Articles of Incorporation lists as one organizational objective 'to promote the general interests of the egg industry.'" As the matrix shows, professional, non-commercial associations generally have statements of purpose that open with and speak prominently about the public weal and the advancement of learning rather than the interests of members alone. And certainly no commitment is made to the economic well being of a profit-oriented group.

The relative point assignments on the matrix (10-5-0) are reflected in the following statements of purpose. The AMA states its purpose as:

> To promote the science and art of medicine and the betterment of the public health.

In contrast, the American Institute of Architects claims as its purpose:

> To elevate the architectural profession as such, and to perfect its members practically and scientifically.

and the Manufacturing Chemists say their purpose is the

> promotion of the interests of the chemical manufacturing industry of the United States and Canada.

Accessibility to Non-Members focuses on the issue of public service and purpose.

10 points if all journals and educational meetings are open to the general public

5 points if only some journals and/or some educational meetings are open to the general public

0 points if the general public may get no journals nor attend any of the association's educational meetings

Although this attribute was not addressed in the NCEN case, we felt it was an excellent measure of one of the differences between profit-oriented trade associations and other associations. It concerns openness of the association and its output to non-members. Along with the AAUP, the American Marketing Association, and the Association of American Geographers, the AMA makes its journals and educational programs available to the general public. The AIA restricts the availability of one journal, as does the MCA, although MCA has recently begun to send a free environment-oriented newsletter to anyone who requests it. In sum, this analysis of six attributes across several associations reveals sharp differences between profit-oriented associations and non-profit professional associations. The differences with respect to origin, character of membership, source of funding and relationships with profit-making groups, nature of publications, stated purpose, and accessibility to non-members are clear and compelling. The Ameriman Medical Association is by this measure, as well as the others reviewed earlier, an educational-scientific association not organized or operated for its own profit or that of its members.

PART IV: Conclusion

The purpose of this study was to determine whether or not the AMA is organized and operated for the profit of itself or of its members. Three different analyses were undertaken. Because the manner in which an organization allocates its resources is a significant indicator of the nature of that organization, a study was made of the Association's budget. An assessment was made of the extent to which its

activities are of direct or indirect economic benefit to the AMA or its members.

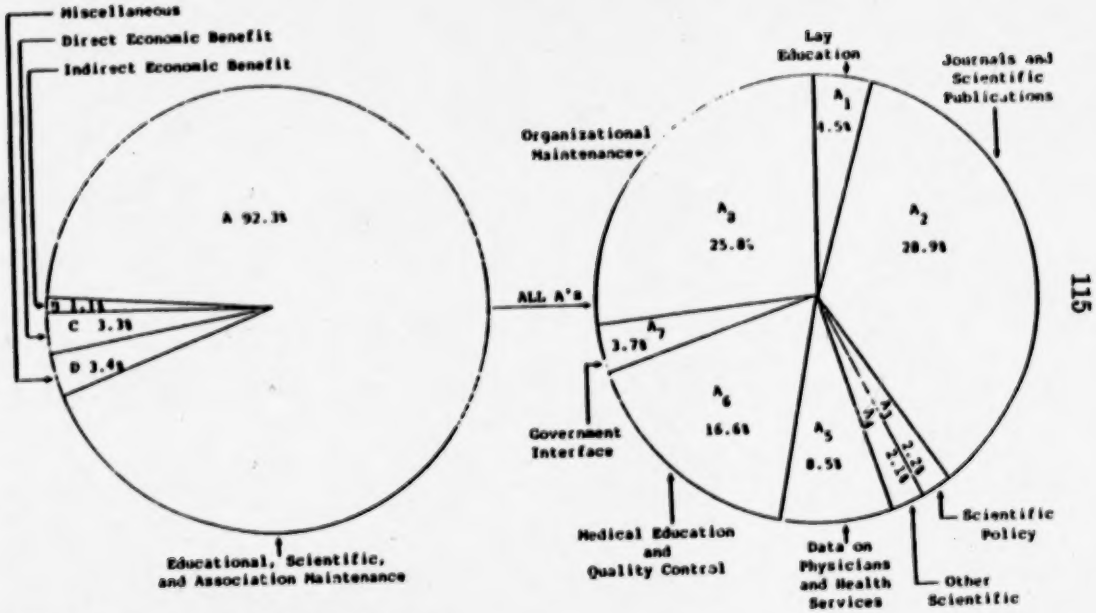
Second, the AMA's income sources and functional expenditures were compared with categories of associations representing some 1,000 associations. The AMA profile was compared with profit-oriented associations (such as manufacturers) as well as non-profit-oriented associations (such as educational).

Finally, AMA was compared with six other associations on the basis of salient attributes developed largely in the National Council on Egg Nutrition case. Of particular importance were the contrasts between the AMA and the Manufacturing Chemists Association, the only commercial trade group which cooperated with the researchers.

All three of these analyses point strongly to a single conclusion: the American Medical Association is a professional association engaged overwhelmingly in scientific and educational activities. Even allowing for a rather broad interpretation of the concept of economic benefit, it is clear that the AMA is neither organized nor operated for the profit of itself or its members. Indeed, it is fundamentally different in character than a profit-oriented trade association.

Appendix I

AMA BUDGET ALLOCATION, 1977



NOTE: All percentages in both charts are to the base total $44,981,686.

Appendix II

Classification of AMA 1977 Project Budgets

A_1

Educational—to Lay Public

24 projects

$2,028,220

Category	Program #	Title	1977 Cost
A_1	JA	Physical Fitness	$ 13,148
A_1	JA	Patient Education	26,954
A_1	JA	Information Services to the Public—Drugs	25,406
A_1	JA	Health Education Consultation to Medical Societies	19,322
A_1	JA	Health Education in Schools, Colleges, and Communities	83,203
A_1	JA	Advancing AMA Health Education Concepts and Policies with Other Groups	48,321
A_1	JA	Responses to Inquiries from the Public for Health Information	372,383
A_1	JA	Development of Professional Standards in Health Education	5,871
A_1	JA	Medicine/Education Committee in School Health	14,325
A_1	JC	Environmental and Public Health, Information, and Promotion	48,117
A_1	JC	Environmental Health	91,427
A_1	JC	Public Health	62,524
A_1	JC	Occupational Toxicology	45,856
A_1	JC	Western Hemisphere Nutrition Congress V	140,443
A_1	JC	Medical School Lectures in Clinical Nutrition	32,215

Category	Program #	Title	1977 Cost
A_1	JC	Medical Instrumentation	$ 3,082
A_1	JC	Provide Information to Physicians on Mental Illness	60,730
A_1	JC	Provide Information to Physicians on Alcoholism	27,473
A_1	JC	Provide Information to Physicians on Drug Abuse	53,445
A_1	JC	Provide Information to Physicians on Mental Health of Children	70,985
A_1	JC	Development of Methodology in Safety Education	22,212
A_1	JC	Research, Information Gathering, Liaison with Others on Foods and Nutrition	141,649
A_1	KA	Information, Analysis, and Consultation on Health Careers	109,168
A_1	KC	Health and Medical Care in Jails	509,961

A_2

Journals & Other Scientific Publications Aimed at Medical Profession

22 projects

$13,009,612

Category	Program #	Title	1977 Cost
A_2	JB	JAMA Foreign Editions	$ 27,240
A_2	JB	JAMA	7,805,807
A_2	JB	American Journal of Diseases of Children	463,830
A_2	JB	Archives of General Psychiatry	424,152

Category	Program #	Title	1977 Cost
A_2	JB	Archives of Internal Medicine	$653,215
A_2	JB	Archives of Neurology	335,646
A_2	JB	Archives of Ophthalmology	515,458
A_2	JB	Archives of Otolaryngology	375,453
A_2	JB	Archives of Pathology and Laboratory Medicine	225,111
A_2	JB	Archives of Surgery	521,006
A_2	JB	Archives of Dermatology	546,309
A_2	JC	Drug Evaluation Book	428,290
A_2	JC	Medical Terminology	18,024
A_2	JC	Current Medical Information and Terminology (CMIT)	76,139
A_2	JC	Research, Bibliography, and Photocopy Services for Physicians	156,472
A_2	JC	Dissemination of Drug Information to the Scientific Community	103,653
A_2	JC	Drug Nomenclature Review	52,884
A_2	JC	Provide Information on Blood Transfusion and Tissue Transplantation	17,540
A_2	JC	Sports Medicine	34,602
A_2	JC	Handbook on Human Sexuality	15,768
A_2	KC	Health Systems Planning and Regulation	179,170
A_2	KF	Computers and Medicine Newsletter	33,843

A_3

Scientific Policy

18 projects

$977,526

Category	Program #	Title	1977 Cost
A_3	JC	Monitor New Techniques and Products on Cutaneous Health and Cosmetics	$ 4,378
A_3	JC	Consultation on Scientific Issues	30,151
A_3	JC	AMA-Food Industry Liaison Committee	13,026
A_3	JC	Maternal and Child Care, Committee on	17,968
A_3	JC	Food Science and Regulations	66,439
A_3	JC	Clinical Nutrition	160,452
A_3	JC	National Committee on Drugs	26,030
A_3	JD	Council on Scientific Affairs	46,211
A_3	KA	National Joint Practice Commission	48,345
A_3	KA	Review and Analysis of Legislation Affecting Health Manpower	48,424
A_3	KA	Information, Analysis, and Consultation on Nursing	45,967
A_3	KA	Information, Analysis, and Consultation on Health Manpower	68,281
A_3	KB	Long-Term Care Facility Liaison	47,170
A_3	KB	JCAH Liaison	230,371
A_3	KE	Health Care Financing—Policy and Information	16,406

Category	Program #	Title	1977 Cost
A_3	KE	Alternative Health Care Financing Systems	$ 10,471
A_3	NC	AMA Interspecialty Advisory Board	66,250
A_3	PJ	Liaison with Scientific Community, Government, and Other Health Agencies	11,186

A_4

Other Scientific

15 projects

$935,760

Category	Program #	Title	1977 Cost
A_4	JC	Memberships and Grants—Health Agencies	$ 58,040
A_4	JC	Goldberger Scholarships	54,776
A_4	JC	Emotionally Disabled Physician	73,108
A_4	JC	Adopted Names Council (United States)	28,313
A_4	JC	Ad Hoc Committee on Antibiotic Utilization	11,432
A_4	JC	Memberships and Grants—Scientific	11,127
A_4	KB	Physician Relations with the Aging	39,275
A_4	KF	Computers in Medicine	16,907
A_4	KF	Computers in Medicine Issue Analysis	26,483
A_4	LD	Memberships and Grants—Allied Health	4,863

Category	Program #	Title	1977 Cost
A_4	PJ	Library Resource Materials —Books, Journals, Microfilm	$211,760
A_4	PJ	Library and Archival Services to Science Writers, Health Educators, and Lay Public	128,314
A_4	PJ	Crerar Library Membership	1,211
A_4	KF	Computers in Medicine Liaison Activities	102,705
A_4	KF	Current Procedural Terminology	167,446

A_5

Data on Physicians, Health Care Delivery, and Health Care Services

43 projects

$3,815,005

Category	Program #	Title	1977 Cost
A_5	KC	National Health Service Corps	$312,782
A_5	KC	Emergency Medical Services	218,243
A_5	KC	Rural Health Systems	110,911
A_5	PD	Collection/Maintenance—AMA Medical Student Masterfile	153,086
A_5	PD	Data Collection/Maintenance of Information on Housestaff Physicians	114,385
A_5	PD	Data Collection and Maintenance of Information on AMA Physician Masterfile —General	217,789

Category	Program #	Title	1977 Cost
A_5	PD	Census of Physicians' Professional Activities	$558,736
A_5	PD	Collection and Maintenance of Information on AMA Support Files	94,118
A_5	PD	Dissemination of AMA Student and Physician Masterfile Data	124,252
A_5	PD	Quality Control of Physician/ Student Masterfile Data	47,414
A_5	PD	Verification of Data Output from AMA Files	56,468
A_5	PD	National Advisory Committee on Physician Statistics	33,727
A_5	PD	AMA Data Systems Enhancements—Physicians Professional Activities Data Collection System	190,048
A_5	PD	AMA Data Systems Enhancements—Foreign Medical Graduates Support File Development	67,055
A_5	PD	AMA Continuing Medical Education Data System	66,799
A_5	PD	License Re-registration Data Collection—Feasibility Study	43,661
A_5	PD	Hospital Staff Privileges Data Systems—Feasibility Study	2,776
A_5	PD	Sub-specialty Certification Data Collection—Feasibility Study	1,998
A_5	PD	Data Release Policy and Issue Papers	22,186

Category	Program #	Title	1977 Cost
A_5	PD	AMA Data Base Information Resource Papers	$ 9,816
A_5	PE	Analyses of Malpractice and Professional Liability	56,831
A_5	PE	Commission on the Cost of Medical Care	293,705
A_5	PD	Development and Maintenance of Group Practice Update System	73,346
A_5	PD	Periodic Survey of Physicians	90,022
A_5	PE	Analysis of Institutions Affecting Medical Care Delivery	10,338
A_5	PE	Distributional Characteristics of Health Manpower	60,998
A_5	PE	Analysis of Physician Mobility	88,833
A_5	PE	Measurement and Determination of Physician Services	638
A_5	PE	Profile of Medical Practice (Red Book)	64,238
A_5	PE	Publication of Socioeconomic Issues of Health	39,912
A_5	PE	Physician Distribution and Medical Licensure	96,756
A_5	PE	FMG Book	62,931
A_5	PE	Health Service Area and State Distribution of Physicians	75,521
A_5	PD	Dissemination of Non-Masterfile Data	49,067

Category	Program #	Title	1977 Cost
A_5	PE	Disseminating Published Information	$ 12,017
A_5	PE	Center Critiques and Commentary	66,809
A_5	PE	Maintenance and Management of Data Information Center Resources and Facilities	6,806
A_5	PE	Conducting Selected Literature Searches	6,806
A_5	PE	Feasibility Study for Modeling a Health Care Delivery System	1,446
A_5	PE	Development of a Secondary Data Base	6,548
A_5	PJ	Medical Socioeconomic Research Sources—Research Services and Support	41,982
A_5	KG	Council on Medical Service	148,864
A_5	KC	Home Health Care	14,341

A_6

Medical Quality Control, Medical Education, & Continuing Medical Education

78 projects

$7,452,916

Category	Program #	Title	1977 Cost
A_6	LA	Accreditation of Undergraduate Medical Education	$262,838
A_6	LA	Information, Analysis, and Consultation on Undergraduate Medical Education	139,298

Category	Program #	Title	1977 Cost
A_6	LA	AMA-ERF Medical Research and Education Support Project	$119,160
A_6	LA	Membership and Grants—Undergraduate Medical Education	4,872
A_6	LB	Directory of Accredited Residencies	169,112
A_6	LB	Residency Accreditation—Specialist Site Visits	134,634
A_6	LB	Accreditation of Residencies—Survey of Residency Programs	690,117
A_6	LB	Residency Accreditation—RRC for Radiology	27,438
A_6	LB	Residency Accreditation—RRC for Thoracic Surgery	26,174
A_6	LB	Residency Accreditation—RRC for Urology	26,978
A_6	LB	Residency Accreditation—RRC for Pathology	29,095
A_6	LB	Residency Accreditation—RRC for Orthopedic Surgery	30,733
A_6	LB	Residency Accreditation—RRC for Opthalmology	18,697
A_6	LB	Residency Accreditation—RRC for Neurological Surgery	17,871
A_6	LB	Residency Accreditation—RRC for Internal Medicine	45,665
A_6	LB	Residency Accreditation—RRC for Obstetrics and Gynecology	43,600
A_6	LB	Residency Accreditation—RRC for Family Practice	43,773

Category	Program #	Title	1977 Cost
A_6	LB	Residency Accreditation—RRC for General Practice	$ 10,303
A_6	LB	Residency Accreditation—RRC for Dermatology	13,515
A_6	LB	Residency Accreditation—RRC for Colon and Rectal	11,328
A_6	LB	Residency Accreditation—RRC for Anesthesiology	25,357
A_6	LB	Residency Accreditation—RRC for Pediatrics	36,580
A_6	LB	Residency Accreditation—RRC for Physical Medicine and Rehabilitation	24,352
A_6	LB	Residency Accreditation—RRC for Plastic Surgery	20,701
A_6	LB	Residency Accreditation—RRC for Preventive Medicine	19,359
A_6	LB	Residency Accreditation—RRC for Psychiatry and Neurology	33,082
A_6	LB	Residency Accreditation—RRC for Allergy and Immunology	18,184
A_6	LB	Residency Accreditation—RRC for Otolaryngology	24,197
A_6	LB	Residency Accreditation—RRC for Nuclear Medicine	19,028
A_6	LB	Residency Accreditation—RRC for General Surgery	45,577
A_6	LB	Information, Analysis, and Consultation on Graduate Medical Education	115,133
A_6	LC	Accreditation of Continuing Medical Education	236,926

Category	Program #	Title	1977 Cost
A_6	LC	Appraisal of Audiovisual and Other Teaching Materials in Continuing Medical Education	$110,019
A_6	LC	National Conference on Continuing Medical Education	37,627
A_6	LC	Information, Analysis, and Consultation in Continuing Medical Education	101,984
A_6	LD	Contract: Workshops and Manual for Allied Health Evaluation	165,036
A_6	LD	Information, Analysis, and Consultation on Allied Health Education	190,336
A_6	LD	Directory of Accredited Allied Health Education Programs	113,431
A_6	LD	Accreditation of Allied Health Education	333,697
A_6	LE	Physician Self-Assessment	109,090
A_6	LE	PRA Computer Tabulated Information Service (PRACTIS)	22,517
A_6	LE	Information and Analysis—Certification and Licensure	40,578
A_6	LF	Investigate and report on quackery and professional qualifications of physicians	40,882
A_6	LF	Peer Review Activities	75,095
A_6	LF	Ad Hoc Committee on PSRO	56,467
A_6	LF	PSRO Activities	73,897
A_6	LF	Quality Assurance Conferences	31,415

Category	Program #	Title	1977 Cost
A_6	LG	Clinical Convention, Scientific Program	$434,488
A_6	LG	Regional Postgraduate Courses	439,950
A_6	LG	International Postgraduate Courses	5,425
A_6	LG	Annual Convention, Scientific Program	663,364
A_6	LG	Audio-Visual and Self-Study Programs	374,546
A_6	LG	AMA Congress on Occupational Health	51,580
A_6	LG	Physician Orientation in Health & Safety	53,912
A_6	LG	Council on Continuing Physician Education	109,246
A_6	LG	Research, Information Gathering, and Liaison with Other Organizations—Continuing Medical Education	19,344
A_6	LG	AMA 1978 Continuing Physician Education Catalog	34,333
A_6	LG	Course on Venereal Diseases, Scientific and Clinical Aspects	20,033
A_6	LG	Course on Air Pollution and Health Effects	14,181
A_6	LG	Future Winter Scientific Meeting	6,308
A_6	LG	Future Regional Post-graduate Courses	11,183
A_6	LG	Future Annual Convention, Scientific Program	12,130
A_6	LG	Conference on the Medical Aspects of Sports	34,308

Category	Program #	Title	1977 Cost
A_6	LG	Congress on Environmental Health	$ 12,202
A_6	LH	Liaison Committee for Specialty Boards	14,770
A_6	LH	Advisory Committee on Allied Health Education	66,455
A_6	LH	Annual Congress on Medical Education	61,500
A_6	LH	Liaison Committee on Medical Education	88,452
A_6	LH	Council on Medical Education	207,713
A_6	LH	Advisory Committee on Undergraduate Medical Education	32,353
A_6	LH	Advisory Committee on Graduate Medical Education	27,987
A_6	LH	Advisory Committee in Continuing Medical Education	48,875
A_6	LH	Liaison Committee on Continuing Medical Education	99,048
A_6	LH	Liaison Committee for Graduate Medical Education	150,895
A_6	LH	Coordinating Council on Medical Education	156,934
A_6	NB	Speakers and Leadership Training	107,063
A_6	NE	Student Loan Project	104,372
A_6	NE	Rock Sleyster Scholarship	4,218

A_7

Government Interface

11 projects

$1,650,410

Category	Program #	Title	1977 Cost
A_7	MB	Liaison with Government Agencies	$189,228
A_7	MB	Congressional Liaison	499,059
A_7	MB	Legislative Roundup	102,456
A_7	MB	Monitor and Analyze Health Legislation and Regulations	236,430
A_7	MB	Preparation of Statements and Briefing Activities	158,759
A_7	MB	AMA Health Legislation Proposals	51,428
A_7	MB	Council on Legislation	155,530
A_7	MB	Coalitions	42,474
A_7	MC	State Legislation and Regulation Activities	163,456
A_7	NB	National Speakers Bureau	23,606
A_7	PE	Analysis of and Regulation Initiatives Affecting Health Care Providers	27,984

A_8

Organizational Maintenance & Operations

73 projects

$11,608,265

Category	Program #	Title	1977 Cost
A_8	PK	Graduate Program in Medical Society Administration	$ 72,625

Category	Program #	Title	1977 Cost
A_s	PK	American Retired Physicians Association	$ 18,270
A_s	PK	American Association of Medical Society Executives (AAMSE) Advisory Committee	17,100
A_s	PK	AMA Newsletter	133,140
A_s	PK	Administrative Internships	—
A_s	PK	Advisory Committee on Services to Young Physicians	42,269
A_s	PM	Section Council on Obstetrics and Gynecology	4,100
A_s	PM	Section Council on Ophthalmology	4,100
A_s	PM	Section Council on Orthopedic Surgery	4,100
A_s	PM	Section Council on Otorhinolaryngology	4,100
A_s	PM	Section Council on Pathology	4,100
A_s	PM	Section Council on Pediatrics	4,100
A_s	PM	Section Council on Physical Medicine and Rehabilitation	4,100
A_s	PM	Section Council on Preventive Medicine	4,100
A_s	PM	Section Council on Psychiatry	4,100
A_s	PM	Section Council on Radiology	4,100
A_s	PM	Section Council on Urology	4,100

Category	Program #	Title	1977 Cost
A_s	PM	Section Council on Neurology	$ 4,100
A_s	PM	Section Council on Cardiovascular Disease	184
A_s	PM	Section Council on Plastic, Reconstructive and Maxilofacial Surgery	4,100
A_s	PM	Section Council on Emergency Medicine	4,100
A_s	PM	Section Council on Nuclear Medicine	4,100
A_s	PM	Section Council on Allergy	4,100
A_s	PM	Section Council on Anesthesiology	4,100
A_s	PM	Section Council on Clinical Pharmacology and Therapeutics	4,100
A_s	PM	Section Council on Colon and Rectal Surgery	4,100
A_s	PM	Section Council on Dermatology	4,100
A_s	PM	Section Council on Diseases of the Chest	4,100
A_s	PM	Section Council on Family and General Practice	4,100
A_s	PM	Section Council on Gastroenterology	4,100
A_s	PM	Section Council on General Surgery	4,100
A_s	PM	Section Council on Internal Medicine	4,100

Category	Program #	Title	1977 Cost
A_8	PM	Section Council on Military Medicine	$ 4,100
A_8	PM	Section Council on Neurological Surgery	4,100
A_8	RA	Contingency Funds Provision	1,832,258
A_8	MD	Press services, press originated	173,218
A_8	MD	Press services; AMA originated	188,341
A_8	MD	Audio/Visual Public Relations Programs	241,388
A_8	MD	Special Communications Programs	57,899
A_8	ME	AM News	3,051,520
A_8	ME	Impact	622,227
A_8	NA	AMA Membership Reports	33,584
A_8	NA	Membership Communication	624,861
A_8	NA	Membership Billing and Collection	299,108
A_8	NA	Internal Member Activities	—
A_8	NA	Membership Activities Liaison with Component and Constituent Societies	484,965
A_8	NA	Membership Services	226,864
A_8	NB	Leadership Conference	191,511
A_8	NB	Services to AMA Auxiliary	29,176
A_8	NB	Fifty Year Club of American Medicine	3,901
A_8	NB	Federation Liaison	581,985
A_8	NB	Candidate Selection	—

Category	Program #	Title	1977 Cost
A_s	NC	Specialty Society Liaison	$179,405
A_s	NC	Section Council Liaison	34,380
A_s	ND	Housestaff Services	109,680
A_s	ND	Intern and Resident Business Session	116,331
A_s	ND	Survey of Young Physicians	19,411
A_s	NE	Medical Student Services	125,191
A_s	NE	Medical Student Business Session	59,001
A_s	PB	EDP Planning Systems Development	10,134
A_s	PD	Dissemination of Biographic Profile Data—Students and Physicians	189,748
A_s	PD	Medical Computer Assistance Program	696,838
A_s	PD	Membership Opinion Survey	86,658
A_s	PE	Policy Issue Papers	41,605
A_s	PE	Program Development and Evaluation	—
A_s	PI	Citation (4)	109,640
A_s	PI	Council on Constitution and Bylaws (6)	—
A_s	PI	Judicial Council (5)	87,368
A_s	PI	Legal Services to the Professions (I)	469,878
A_s	PK	Liaison with Civic Organizations	27,685
A_s	MD	PR counseling and administrative services	116,701
A_s	MD	Media Relations	79,476
A_s	NB	New Medical Executives School	12,041

B

Programs Offering Indirect Economic Benefit to Members

6 projects

$496,705

Category	Program #	Title	1977 Cost
B	JC	Occupational Health	$ 93,890
B	KB	Medical Staff Training Project	135,829
B	KD	Practice Management Project	126,499
B	MA	Negotiation Planning Services to Medical Societies	19,869
B	PE	Economics of Medical Practice	77,863
B	PE	Analysis of Medical Group Practice	42,755

C

Programs Offering Direct Economic Benefit to Members

13 projects

$1,499,750

Category	Program #	Title	1977 Cost
C	KD	Financial Management Project	$ 29,072
C	KD	Medical Assistant Management Project	75,246
C	KD	Young Physicians Practice Management Project	62,968
C	KD	Practice Management Publications	28,337

Category	Program #	Title	1977 Cost
C	KE	Health Care Financing Liaison	$ 66,608
C	MA	Negotiation Consulting Services	46,867
C	MA	Negotiation Education	208,213
C	MA	Negotiation Information	75,400
C	MP	Professional Liability Insurance	161,969
C	NA	AMA Members Insurance Development	16,592
C	NA	AMA Members Retirement Plan	691,875
C	NA	Operational Members Insurance Programs	15,006
C	NA	AMA Group Disability Insurance	21,597

D

Miscellaneous

6 projects

$1,507,517

Category	Program #	Title	1977 Cost
D	KB	Medical Society—Medical Staff Advocate Newsletter	$ 62,467
D	KB	Medical Staff/Hospital Liaison	$1,855
D	KG	AMA-MGMA-AGPA Joint Liaison Committee	11,959
D	LE	Physician's Recognition Award	211,090
D	KC	Physicians' Placement Service	269,764
D	NB	Services to AMPAC	900,382

Appendix III

Notes on use of the ASAE Report

1. All associations with corporate membership include all associations which have as members organizations, firms, or other collective bodies. An example is the Association of American Law Schools.
2. All associations with individual membership include all associations which have as members individuals, such as the American Association of University Professors.
3. Corporate member associations in the manufacturing industry include associations that have as members manufacturing organizations or firms. The Equipment Manufacturers Association would be an example.
4. Corporate member associations in health care are firms and organizations engaged in the health industry. The American Hospital Association is in this category.
5. Individual member associations in medical professions are professional associations such as the American College of Physicians, the American Nurses Association, and the American Medical Association.
6. Individual member associations in educational professions are largely societies of academics. The American Association of University Professors is included here.
7. Individual member associations in legal professions are largely societies of individual lawyers such as the American Association of Trial Lawyers.

The first two of these seven categories of associations were chosen because together they comprise the entire data base of 1,006 associations surveyed. They provide the macro picture of association operations.

Corporate member associations in manufacturing provide a comparison with commercial trade associations.

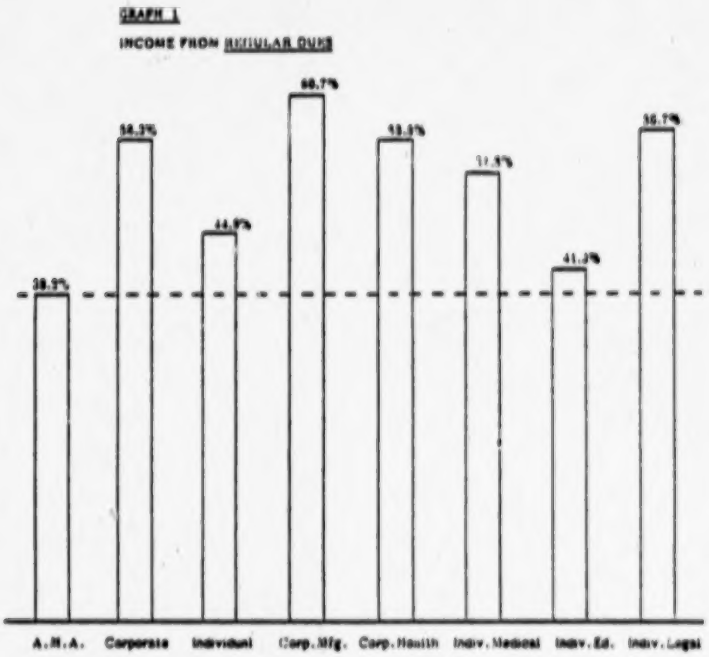
Corporate member associations in health and individual member associations in medical professions were chosen because they were directly pertinent to the kind of environment the AMA operates in.

Individual member associations in educational and legal professions were chosen to represent unquestioned examples of professional associations.

In all cases, the examples chosen were solely the responsibility of the researchers. All data used were drawn from the independently collected questionnaires used by Touche Ross & Co. in compiling the ASAE Report.

Appendix IV

Comparative Operating Ratio Income and Expense Graphs

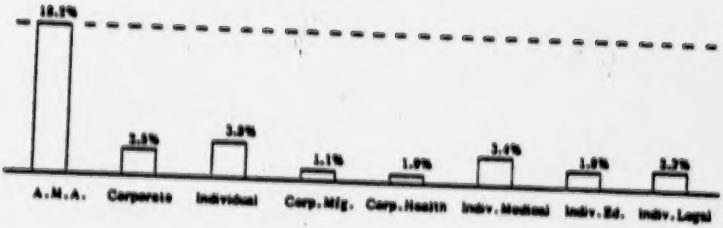


GRAPH 2

INCOME FROM ASSOCIATE GIFTS

GRAPH 3

INCOME FROM SPECIAL PAYMENTS, ASSESSMENTS, ENTRANCE AND INITIATION FEES

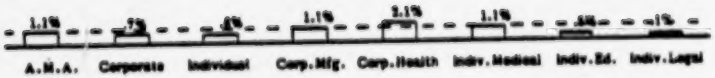


GRAPH 4

INCOME FROM EDUCATIONAL PROGRAMS

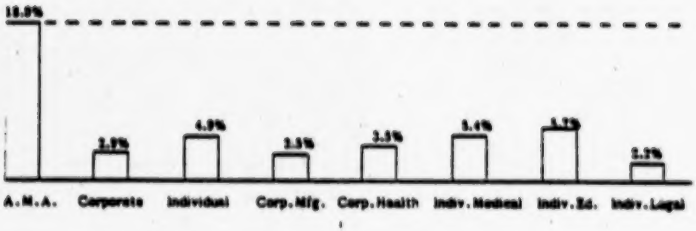
GRAPH 3

INCOME FROM CERTIFICATION, ACCREDITATION AND STANDARDIZATION



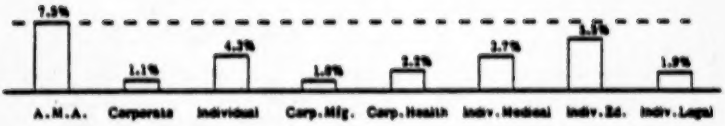
GRAPH 6

INCOME FROM PUBLICATION ADVERTISING



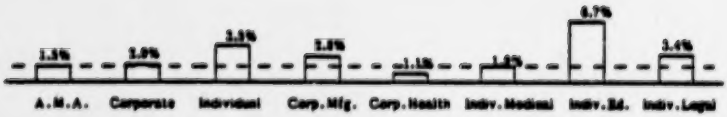
GRAPH 7

INCOME FROM SUBSCRIPTION SALES



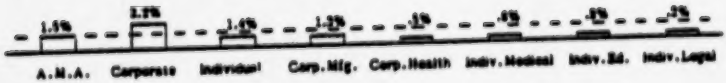
GRAPH 8

INCOME FROM JOURNAL SALES OTHER THAN SUBSCRIPTION SALES



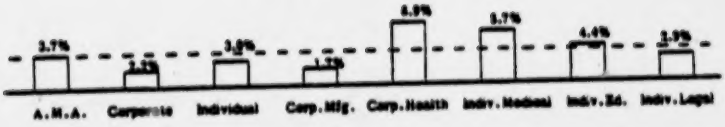
GRAPH 9

INCOME FROM INSURANCE



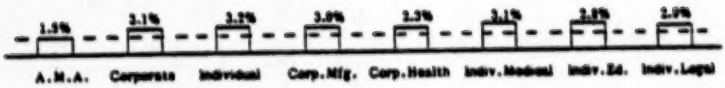
GRAPH 10

INCOME FROM GRANTS



GRAPH 11

INCOME FROM INVESTMENTS



GRAPH 12

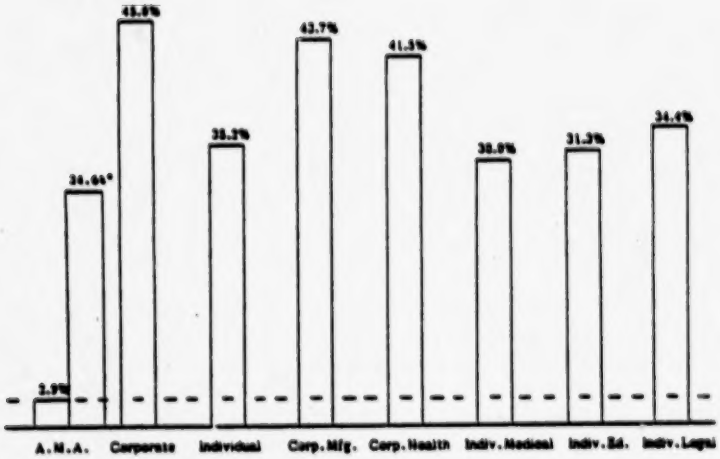
INCOME OTHER THAN FROM THE ABOVE CATEGORIES

The Other category breaks down into:

Royalties	4.8
Miscellaneous	1.3
	6.1

GRAPH 13

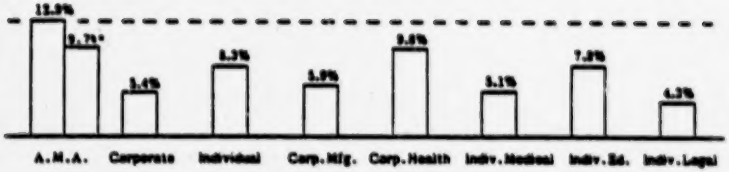
EXPENDITURES FOR EXECUTIVE AND ADMINISTRATIVE ACTIVITIES



*See footnote 1 on page 11 for an explanation of this figure.

GRAPH 14

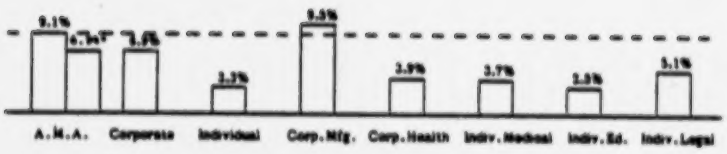
EXPENDITURES FOR MEMBERSHIP



*See footnote 1 on page 11 for an explanation of this figure.

GRAPH 15

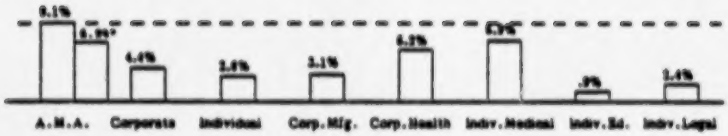
EXPENDITURES FOR PUBLIC RELATIONS



*See footnote 1 on page 11 for an explanation of this figure.

GRAPH 16

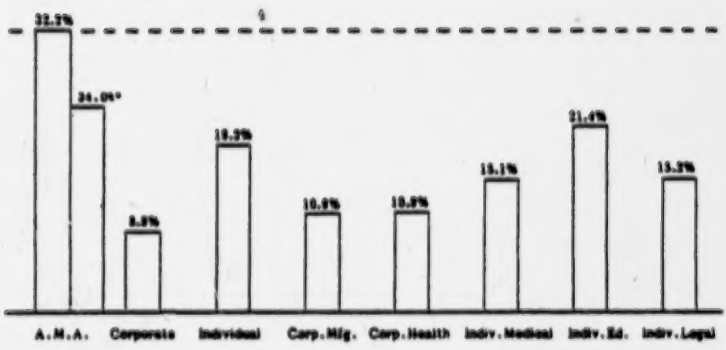
EXPENDITURES FOR GOVERNMENT RELATIONS



*See footnote 1 on page 11 for an explanation of this figure.

GRAPH 17

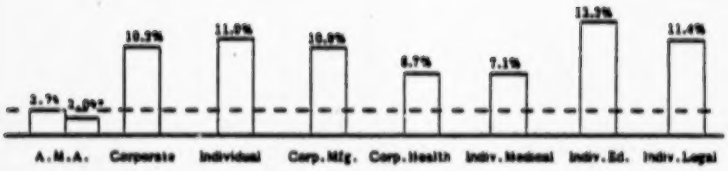
EXPENDITURES FOR PUBLICATIONS



*See footnote 1 on page 11 for an explanation of this figure.

GRAPH 18

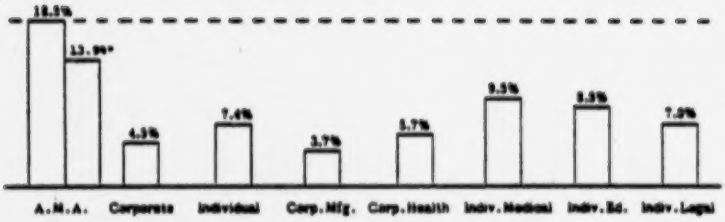
EXPENDITURES FOR CONVENTIONS AND MEETINGS



*See footnote 1 on page 11 for an explanation of this figure.

GRAPH 19

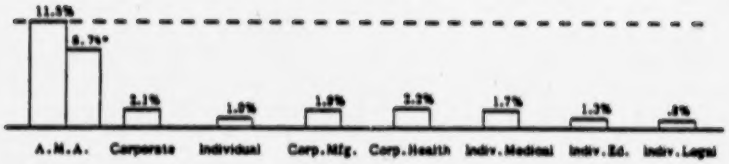
EXPENDITURES FOR EDUCATIONAL PROGRAMS



*See footnote 1 on page 11 for an explanation of this figure.

GRAPH 20

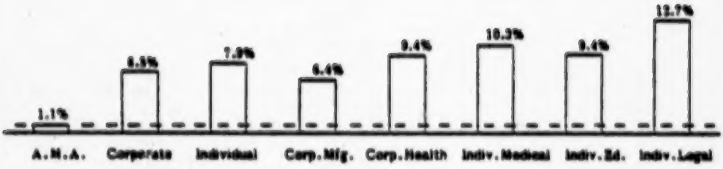
EXPENDITURES FOR CERTIFICATION, ACCREDITATION, AND STANDARDIZATION



*See footnote 1 on page 11 for an explanation of this figure.

GRAPH 21

EXPENDITURES FOR ALL OTHER ACTIVITIES EXCEPT THE EIGHT ALREADY LISTED



Appendix V

Interviews with non-AMA Association Officials

Morton Baratz, General Secretary, American Association of University Professors. Washington, D.C. October 11, 1977

Michael Cardozo, former Executive Director, Association of American Law Schools, Washington, D.C. September 29, 1977

Wayne Lemberg, Executive Director, American Marketing Association, Chicago, Ill. October 5, 1977

Warren Nystrom, Executive Director, Association of American Geographers, Washington, D.C. October 29, 1977

Victor Peterson, Vice President, Manufacturing Chemist Association, Washington, D.C. October 12, 1977

Nancy Truscott, Legal Council and Assistant Secretary, American Institute of Architects, Washington, D.C. October 12, 1977

Appendix VI

List of AMA Officials Interviewed

J. T. Baker, Division of Marketing
L. Fenninger, Group Vice President, Education
A. J. Finkel, Group Vice President, Scientific Activities
T. F. Hannon, Group Vice President
B. P. Harrison, Group Vice President
Maynard Heacox, Department of Practice Management
Robert Herbst, Director of Accounting
L. E. Jensen, Center for Health Services Research and Development
C. H. W. Ruhe, Senior Vice President

Appendix VII

Printed Sources Cited

American Medical Association, *Project Account Request Form.* A collection of 311 such forms approved in 1977.

American Society of Association Executives, *Association Operating Ratio Report, 1977* (Washington, D.C.: 1977).

American Society of Association Executives, *1976 Survey of Association Operating Statements.* Document completed by Jan W. Erfert, AMA Director of Finance, and submitted to Touch Ross & Co.

Davis, N. S., *History of the American Medical Association from Its Organization Up to January, 1855* (Philadelphia: Lippincott, Grambo, and Co., 1855).

Library of Congress, General Reference and Bibliography Division and Reference Department, *A Guide to the Study of the United States of America* (Washington, D.C.: United States Government Printing Office, 1960).

Supplement to JAMA: Continuing Education Courses for Physicians. August 15, 1977.

U.S. Department of Commerce, Bureau of the Census, *Historical Statistics of the United States: Colonial Times to 1957* (Washington, D.C.: United States Government Printing Office, 1960).

Other Printed Sources

American Association of University Professors, *Policy Documents and Reports* (Washington, D.C.: January, 1977).

American Association of University Professors Report on Examination with Supplementary Information, Years Ended December 31, 1976 and 1975. Prepared by Main Lafrentz & Co., Washington, D.C.

The American Institute of Architects Annual Report of the Board, 1976.

American Institute of Architects Journal Directory, Vol. 66, No. 5 (Mid-April 1977).

American Medical Association, *Principles Governing Advertising in Publications of the American Medical Association.*

American Medical Association, *What the AMA Dues Dollar Does: A Report to Physicians on the Programs 1976 Revenues Supported* (Chicago: December 1976).

American Society of Association Executives, *Members Appraise Their Associations* (Washington, D.C.: 1972).

American Society of Association Executives, *Nondues Income of Associations* (Washington, D.C.: 1971).

American Society of Association Executives, *Principles of Association Management* (Washington, D.C.: American Society of Association Executives and Chamber of Commerce of the United States, 1975).

Michael H. Cardozo, *The Association Process 1963-1973.* Part I, Section II of the Association of American Law Schools 1975 Annual Meeting Proceedings.

Herold, Arthur L., and George D. Webster, *Antitrust Guide for Association Executives* (Washington, D.C.: American Society of Association Executives, 1976).

Kotler, Philip, *Marketing for Nonprofit Organizations* (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1975).

Policies and Procedures of Associations (Washington, D.C.: American Society of Association Executives, 1974). Compiled by Priestland Associates, Alexandria, Virginia.

Webster, George D., *The Law of Associations* (New York: Matthew Bender & Company, Inc., 1976).

Appendix VIII

Biographies of Staff

Frederick D. Sturdivant is the M. Riklis Professor of Business and Its Environment at the Ohio State University and a Faculty Principal at Management Analysis Center, Inc. He received his Ph.D. from Northwestern University in Business Administration and his M.B.A. from the University of Oregon.

John C. Kirby is a Vice President at Management Analysis Center, Inc. He received his M.S. from the University of Pittsburgh and his M.B.A. from Harvard.

Michael J. Hobor is an Associate at Management Analysis Center, Inc. He holds a Ph.D. in Legal History and an M.B.A., both from the University of Chicago.

CX 2586—
AN ANALYSIS OF THE STURDIVANT REPORT

Prepared for Use in the Matter of the
American Medical Association
Docket No. 9064

By
PAUL J. FELDSTEIN
Professor
School of Public Health
and
Department of Economics
The University of Michigan

TABLE OF CONTENTS

	Page
I. INTRODUCTION	1
II. CONCEPTUAL PROBLEMS INVOLVED IN THE BUDGETING APPROACH USED IN THE STURDIVANT REPORT	4
A. The AMA's Political Activities as a Means of Providing Economic Benefits	4
B. An Analysis Based on Budget Allocations Excludes the Value of Practicing Physicians' Volunteer Time Used by the AMA to Promote Its Members' Economic Interests	6
C. A One Year Budget Analysis Is Inadequate to Indicate an Association's Priorities	8
1. Year to Year Variances in Political Activity	9
2. Previous Investments in Political Activities	10
III. PROBLEMS INVOLVED IN THE STURDIVANT REPORT'S APPLICATION OF THE BUDGET APPROACH	11
A. Unduly Narrow View of Economic Benefit Used in the Report	11
B. AMA Activities that Provide Both Economic and Non-Economic Benefits	13
1. Organizational Maintenance and Operations of the AMA	13
2. Data Collection	14
3. Public and Media Relations	16

Page

C. What Is the Relevant Expenditure Base Upon Which to Calculate the AMA's Commitment to Serving Its Members' Economic Interests? .. 17

1. Members' Dues as the Relevant Expenditure Base 17

2. Treatment of Resources Placed into Reserves 19

3. Basis for Recalculation 20

IV. RECALCULATING THE PERCENT OF THE AMA'S RELEVANT EXPENDITURE BASE THAT PROVIDES ECONOMIC BENEFITS TO AMA MEMBERS 22

A. Activities That Provide an Economic Benefit 22

V. CONCLUSION 24

APPENDIX List of Reclassified Projects 25

I. INTRODUCTION

This paper is an analysis of the report by F. Sturdivant, J. Kirby, and M. Hobor, "Comparative Analysis of the American Medical Association versus Other Associations."[1] There are three parts to the Sturdivant report. The first is a quantitative analysis of the AMA's budget, the second is a comparative analysis of the AMA's budget relative to the operating budgets of over 1,000 other associations, and the third is a "cultural" comparison of the AMA and six other associations.

The Part I analysis of the AMA's expenditures for a single year is aimed at determining whether the AMA is organized for the economic benefit of its members. By subjectively classifying the AMA's project requests for 1977, the authors of the Sturdivant report conclude that 5.8 percent[2] of the AMA's budget was allocated to provide direct and indirect economic benefits to physicians. (SR p. 8, Table 1, Categories B and C and footnote). Examining an organization's budget to infer its purposes is intuitively appealing. However, this approach which may be useful for analyzing a business firm is inappropriate when applied to an association of health professionals, leading to an understatement of the association's economic activity and an incorrect conclusion in this case. Specifically, I will first explain why there are severe conceptual problems in adopting a budget analysis approach for an organization like the AMA. Second, I will discuss the severe problems in the Sturdivant report's actual application of the budget approach in its analysis of the AMA's project requests for

[1] Hereafter referred to as "the Sturdivant report." Page references found in parentheses in the text of this paper also refer to the Sturdivant report ("SR").

[2] This figure includes the dollar amounts listed in a footnote on page 8 of the Sturdivant report which had been erroneously omitted from the authors' original data package.

1977. Finally, I will recalculate the percentage of the AMA's budget that provides economic benefits to its members, based on my own analysis of the AMA's budget and project requests. In so doing, I have reached two overall conclusions:

—First, the budget allocation approach has too many problems to be useful in understanding the AMA's economic relationship to its members.

—Second, even if one were to use such an approach, recognizing its severe limitations, the percentage of the AMA's budget that provides economic benefit to its members is, at a minimum, 35 to 43 percent.

Parts II and III of the Sturdivant report are not analyzed in this paper. Part II is an income and expenses comparison of the AMA with 1,000 other organizations. The main reason for excluding it is that since use of the AMA's income and expenditures in analyzing the nature of its relationship with its members is subject to serious problems, as this paper indicates, comparing the AMA's income and expenses with those of hundreds of other associations compounds the weaknesses of the budgetary approach. This is in part because it requires assumptions to be made about the non-profit orientation of the other associations which the Sturdivant report suggests are similar to the AMA and in part because of the unreliability of the underlying data used in the comparisons.[3]

Part III of the Sturdivant report, a comparative "cultural" analysis of the AMA and six other organizations, is excluded from this analysis because it is subjective in its conclusions on the salient characteristics of the seven organizations and because it is largely based, like Part II, on assumptions about the characteristics of the organiza-

[3] For example, the questionnaire response of the AMA, the organization whose budget has been separately examined, contained a multi-million dollar error which was not corrected by the compilers of the Touche Ross Association Operating Ratio Report.

tion being compared. For example, a non-profit association's current statement of purposes may be totally at variance with its original statement of purposes and with how, in fact, it acts. Moreover, much of the Part III analysis proceeds from the unjustified assumption that the relationship between the AMA and practicing physicians is greatly different from the relationship between corporate trade associations and their members.

II. CONCEPTUAL PROBLEMS INVOLVED IN THE BUDGETING APPROACH USED IN THE STURDIVANT REPORT

The following difficulties involved in using the budget approach to analyze the extent to which an association confers economic benefits on its members demonstrates that any estimate based on a budget approach will be greatly *understated.*

A. *The AMA's Political Activities as a Means of Providing Economic Benefits*

The most important economic benefit an association such as the AMA can provide to its members comes from political activity to secure favorable legislative and administrative action and to oppose governmental programs which are economically unfavorable to its members. Individual physicians cannot afford to spend the time or money to lobby for legislation that would benefit all physicians. It is more economical for such individuals to join an association that will represent all members of this profession. However, the current and historic political role of the AMA is totally ignored in the Sturdivant report.

If one examines the history of the AMA's legislative activity, it becomes fairly clear that the AMA has acted in

the economic interests of its members.[4] An obvious example of legislative activity by the AMA to provide economic benefits to its members was the successful effort by the AMA to have Congress modify the Keogh law. According to the AMA, "This (modification) potentially saves a physician . . . 14 times [his] dues to the AMA."[5]

Perhaps of more importance are other legislative approaches where the economic benefits to physicians may be less obvious to the public. The AMA has, for example, opposed federal government legislation and administrative attempts to control the ability of physicians to set their own fees. It opposed the Economic Stabilization Program which placed limits on physicians' fees and has opposed certain proposals for national health insurance (Kennedy Corman) that would adversely affect physicians who remain in fee-for-service practice. In fact, the AMA's approach to legislation on certification of physician competence,[6] payment for physician services, organization of medical care,[7] and the role of auxiliary health workers,[8] has been entirely consistent with the economic interests of the existing members of the medical profession.[9]

---

[4] Paul J. Feldstein, *Health Associations and the Demand for Legislation: The Political Economy of Health,* (Cambridge, Mass.: Ballinger Publishing Company, 1977).

[5] American Medical Association. *If You Haven't Paid Your Assessment Because You Don't Think the AMA has Demonstrated Leadership . . . Check the Record* (CX 258).

[6] The AMA has not supported legislation requiring retaining or re-examination of practicing physicians.

[7] The AMA has, over the years, favored fee-for-service over alternative forms of health care delivery, such as health maintenance organizations and prepaid group practice.

[8] The AMA consistently presses for requirements that most nonphysician health personnel be allowed to practice only under the control of physicians.

[9] This is not to say that all of these positions are necessarily contrary to the public interest.

The continual excess demand for medical education and the willingness of many qualified students to pay higher costs to study medicine overseas in order to return and practice medicine in this country signify the high degree of economic status of the medical profession. Physicians have also earned relatively high incomes in this country for many years. It is believed that these indications of the economic well-being of medicine as a profession are in part a result of successful legislative activity on behalf of physicians.[10]

The economic value to its members of the AMA's legislative activity *greatly exceeds* the dues that a member must pay to join the AMA (e.g., economic value of the Keogh law).[11] Because of this, the physician-member of the AMA may be willing to have the AMA undertake a large number of non-economic activities. If it were not for the economic benefits it provides to its members, the AMA might not be able to raise money from its members to spend on non-economic activities.

Political activities to provide legislative benefits to physicians may account for only a small percentage of the AMA's

---

[10] Feldstein, *Health Associations;* Elton Rayack, *Professional Power and American Medicine: The Economics of the American Medical Association* (Cleveland: World Publishing Co., 1967); Rosemary Stevens, *American Medicine and the Public Interest* (New Haven: Yale University Press, 1971).

[11] Much like its political activities, the AMA's relations with health insurance companies and its own insurance programs for its members can also result in economic value greatly exceeding their budgetary costs. For example, AMA has stated that it "was instrumental in getting insurance companies to provide broader ambulatory insurance coverage which has . . . provided physicians with a greater percentage of reimbursement for their services." American Medical Association, "If You Haven't Paid Your Assessment . . ." (CX 258) Over the years AMA has also assisted in the development of physician-controlled Blue Shield plans whose payment plans and coverages have generally benefitted physicians.

budget, but the economic value to physicians of political activities is large. Thus, the AMA can spend a major portion of its members' dues on non-economic programs. An analysis of the AMA's budget is misleading, therefore, if it concludes that because a large percentage of the AMA's budget goes to non-economic activities, the AMA does not operate for the economic benefit of its members.

B. *An Analysis Based on Budget Allocations Excludes the Value of Practicing Physicians' Volunteer Time Used by the AMA to Promote Its Members' Economic Interests*

The AMA budget does not provide any indication of the efforts on behalf of the AMA provided by non-employees of the AMA to promote the economic interests of member physicians. As such, the AMA budget understates the amount of resources used by the AMA to provide economic benefits. For example, practicing physicians testify frequently for the AMA before Congress on matters of economic interest to the profession.[12] Other practicing physicians are used by the AMA both to define physicians' conception of the profession's interests and to promote physicians' economic interests. Examples include those physicians who participate in the House of Delegates, councils, and committees of the AMA, as well as those physicians who are trained by the AMA to speak on non-scientific matters such as federal health legislation.[13] Practicing physicians

[12] *What the AMA Dues Dollar Does, A Report to Physicians on the Programs 1976 Revenues Supported,* American Medical Association, December, 1976, p. 5 (RX 5).

[13] *Project Account Request Forms:* National Speakers Bureau. Project Definition: Train, brief and appoint medical profession spokesmen to fill requests for non-scientific engagements, mainly on topics concerning major federal, health legislation ($825,606 project classified as A7—non-profit government interface—in the Sturdivant report); Speakers and Leadership Training (A6, $107,065).

have also served as representatives of the AMA to various organizations that affect the economic interest of physicians, including the National Association of Blue Shield Plans, which develops policies that help determine physician reimbursement levels.

Even though some of these practicing physicians representing the AMA may receive small honorariums, the value of their time greatly exceeds any nominal payment they may receive. Because it excludes the efforts of practicing physicians from the analysis, a budget allocation analysis may substantially understate the AMA's activity in areas that affect the economic interests of physicians.

An analysis of the AMA budget also cannot assess the economic value of the AMA's efforts to promote political activity and contributions by local physicians (and even their wives) to further physicians' economic interests. For example, a number of communications from the AMA to its members, such as the *American Medical News,* provide the physician member with a certain viewpoint on legislation. As a result of the political impressions that result from reading these communications, local physicians may be more inclined to provide political support to legislators who are sympathetic to the AMA's political positions. Political activity by local physicians may include political contributions to increase the election chances of sympathetic legislators. The information presented in AMA publications may also result in local physicians becoming sufficiently concerned over certain legislative proposals to personally contact, by writing or by visiting, their elected representatives. Such individual support by local physicians is important for the achievement of the AMA's legislative goals. The value of such contacts and other political efforts by local physicians, resulting from the AMA's communications with its members, is not represented in the AMA's budget.

C. *A One Year Budget Analysis Is Inadequate to Indicate an Association's Priorities*

An anlysis of budget expenditures for one year provides a false impression of an association's depth of commitment to its members economic interests, the extent of resources an organization is *willing* to expend to protect the economic interests of its members, and the continuing effects of its past efforts on its members' behalf.

1. *Year to Year Variances in Political Activity*

The Sturdivant report analyzes the AMA's budget for only one year—1977, a non-election year. A non-election year may require relatively little of an organization's resources for political activities. In an election year or when a legislative issue surfaces that involves the economic interests of its members, an organization is likely to spend proportionately more dollars in addition to exhorting its members to contact their legislators to present their viewpoint.[14]

The AMA budgets considerable amounts of money for political activities in what the Sturdivant report categorizes as non-profit "government interface" activities. In addition, the AMA provides substantial financial support to the American Medical Political Action Committee (AMPAC) to help that entity carry out its programs. In 1977, according to the project request forms, the AMA provided AMPAC with over $900,000.[15] But the amount

[14] While this section discusses expenditures for political activities, much of the reasoning applies as well to other AMA activities, including its early support for the Blue Shield system.

[15] According to a Common Cause three-volume report based on Federal Election Commission data, AMPAC and state level medical political action committees were the heaviest contributors to members of the House Health Subcommittee in the 1976 election and led all interest groups in political contributions with a total of $1,730,000. *Washington Report on Medicine and Health* 32 No. 4 (1978):7.

of money the AMA spends for political purposes probably varies from year to year, according to whether it is an election year or whether there are particular legislative proposals that would have an important economic effect on its members. More than once, the AMA has spent more money than any other lobby group in Washington to influence legislation.[15a] For example, in 1950, the AMA spent $2,595,900 in an attempt to stop passage of President Truman's Medical Insurance Plan.[16] This was almost twice as much as the expenditures of the second-ranked lobbyist.[16a] In the period 1949-1952, the AMA spent $4,678,000 to prevent passage of President Truman's bill.[17] In its unsuccessful attack on Medicare legislation, the AMA spent more than $950,000 in the first quarter of 1965.[18] Thus, the percentage of the AMA's budget going for such legislative activities is almost certainly not constant for each year. Therefore, the Sturdivant report's assumption that 1977 was a typical year is unfounded and its failure to note the variability in budget expenditures and effort during certain periods is misleading.

2. *Previous Investments in Political Activities*

When an organization is attempting to develop initial support from legislators, a heavy political investment is required. Lobbying and encouragement of political activity on behalf of legislators are more extensive when an organization does not already have many legislators who are sympathetic to its members' interests. It is more expensive

[15a] Rayack, *Professional Power*, p. 11.

[16] James G. Burrows, *AMA: Voice of American Medicine* (Baltimore: John Hopkins Press, 1963), p. 374. See also: "The American Medical Association: Power, Purpose and Politics in Organized Medicine," *Yale Law Journal*, Vol. 63, 1955-54, pp. 1010-18.

[16a] Rayack, *Professional Power*, p. 11 .

[17] Stevens, *American Medicine*, p. 426.

[18] Rayack, *Professional Power*, p. 11.

to convince legislators who were elected without any support from an interest group that they should become sympathetic in the future to the group's goals. Thus, it is less costly to maintain legislative support than it is to develop it initially. An analysis of an organization's budget for one year does not indicate the level of political activity that has been maintained in the past to help secure that organization's legislative goals.

III. PROBLEMS INVOLVED IN THE STURDIVANT REPORT'S APPLICATION OF THE BUDGET APPROACH

The above discussion illustrated why an analysis of the AMA's budget would result in a substantial *underestimation* of the extent to which AMA activities provide an economic benefit to its members. The following section shows some of the shortcomings in the Sturdivant report's actual application of the budget approach to the AMA's different activities.

A. *Unduly Narrow View of Economic Benefit Used in the Report*

In attempting to determine which of the AMA's activities provide economic benefits to its members, the authors of the report adopted a very narrow definition of economic benefits. The Sturdivant report acknowledges the economic benefits present in some project requests which were specifically directed to practice management and insurance. For example, those projects designed to increase ". . . the managerial and other skills of non-physicians who aid and assist physicians, by aiding local medical societies, or by providing data of a business sort" were classified as providing an indirect economic benefit (SR p. 6); ". . . projects that directly train the physicians themselves in managerial skills or provide them with benefits such as insurance or

retirement programs" were classified as providing a direct economic benefit to physicians (SR p. 7). (But the report's authors exclude from their two categories of projects providing economic benefit the "Physicians Placement Service" project, placing it in Category D.)[19]

Perhaps it was the authors' unfamiliarity with the field of medical care that led them to exclude from the economic benefits categories any activity, for example, that involved government and legislative activity or the delivery of medical services. To any person who has studied medical care, it is precisely in these areas that the real economic interests of physicians lie. All of the following will have very important effects on physicians' incomes: how physicians are reimbursed under government medical programs, whether non-physicians (e.g., physician assistants and nurse practitioners) can practice independently of physicians who normally receive the fee for services performed by non-physicians, whether and how hospitals which are the physicians' workshops are to be regulated, information for physicians' locational decisions, and whether and how the type of care that physicians provide is to be monitored (e.g., PSRO's). These are some of the crucial economic issues facing physicians.

Realistically, any budget activities that tend to increase or maintain physicians' income, directly or indirectly, should be classified as providing an economic benefit. A list

[19] The classification of projects used in the report was also not internally consistent. For example, Professional Liability Insurance ($161,969) was classified as offering direct economic benefits (Category C), while Analysis of Malpractice and Professional Liability ($56,831) was classified as A5, offering no economic benefit. Similarly, the report classified Health Care Financing Liaison ($66,608) in Category C, offering a direct economic benefit, whereas all other activities dealing with the same subject (e.g., Health Care Financing-Policy and Information and Alternative Health Care Financing Systems, both A3) were classified as offering no economic benefit.

of general categories of activities that affect physicians' incomes are presented and discussed in my book, *Health Associations and the Demand for Legislation.* Generally, these are activities that (a) increase the demand for physicians' services; (b) enable physicians to charge on a fee-for-service basis; (c) lower the price of their complements (the various supplies, facilities and assistance components needed by the physician to increase the amount of services he can provide); (d) increase the prices charged by physician substitutes (or decrease their availability), e.g., excluding optometric services as a reimbursable service under Medicare, thereby raising their price relative to those of ophthalmologists; or (e) decrease the supply of new physicians.

The above list of activities affecting physicians' incomes provides a more logical framework for analyzing the AMA's project request forms than the unduly narrow approach used in the Sturdivant report. When the percentage of the AMA's budget that provides economic benefits to its members is recalculated in the last section of this analysis, the project request forms are reclassified according to the above, broader view of economic benefits, yielding a more realistic picture of the AMA's commitment to its members' economic interests.

B. *AMA Activities That Provide Both Economic and Non-Economic Benefits*

There are many activities of the AMA (according to the project request forms) that provide both economic and non-economic benefits. Based on the information provided in the project request forms, it is virtually impossible to separate the economic from the non-economic benefits in many particular budget requests. The extent to which projects are classified as providing no economic benefit when they in fact do is one important measure of the understatement of the economic activities of the AMA in the

Sturdivant report. The following are some examples of activities that provide both economic and non-economic benefits.

1. *Organizational Maintenance and Operations of the AMA*

The Sturdivant report allocates $11,708,265 to A3, the nonprofit category for Organizational Maintenance and Operations. This category represented 25.8 percent of the AMA's forecasted expenditures for 1977. It is unrealistic to assert that no economic benefits are provided to AMA members by these expenditures which help to carry out *all* its various programs. Included within this category is $1,352,258 earmarked for the Contingency Fund. The Sturdivant report ignores the fact that this money is available to be used on projects benefitting physicians economically.

It is unclear how the Sturdivant report treats the AMA's expenses for its officers' activities, including those of its executive vice president. Apparently, these costs have been allocated as overhead expenses into all the individual project request forms. If so, this could result in understatement of the extent of the AMA's activities promoting physicians' economic interests. This is because its officers are particularly active in legislative activities that provide economic benefits to the AMA's members. As the AMA has stated, "In the Congress just adjourned, AMA officers testified before Congressional health committees twenty-four times on bills affecting the delivery of health care." [20]

Category A8 also contains over $5 million in project requests budgeted for promotion and maintenance of AMA membership and communications to membership. The political influence of an organization depends, in part, on the size of its membership and its cohesiveness on political issues. To the extent that the AMA's membership activities

[20] *What the AMA Dues Dollar Does*, p. 5 (RX 3).

and communications to its members accomplish this cohesiveness, the AMA will be better able to provide economic benefits to its members. That this is recognized by the AMA is acknowledged in the following statement: "To achieve consensus within the federation structure, and thereby the membership, the AMA places great emphasis on communications with the profession. Published on the theory that an informed membership is the AMA's greatest strength, the *American Medical News* appears weekly. . . . It is the vehicle by which AMA keeps 250,000 recipients current on legislative, economic, legal and other non-clinical news." [21] Also important ". . . is the AMA's role as medicine's advocate in the court of public opinion. There, physicians (with less than 0.2% of the population) lack the ballot box clout that counts so heavily. Only through a proficient, *aggressive* organization can their voice be heard and heeded. Only through a *large, strong* AMA, can physicians engage *forcefully* in the public dialogue that is deciding more and more medical issues." [22] Some of the activities in the organizational maintenance category can be more clearly classified as providing an economic benefit; for others it is not so easily determined. The Sturdivant report's failure to allocate activities expenditures according to the economic benefits provided results in an inaccurate assessment of the AMA's activities.

2. *Data Collection*

There are a number of data collection activities classified as nonprofit in Category A5, reflecting budget requests in excess of $5,300,000. Much of the socioeconomic data col-

[21] *What the AMA Dues Dollar Does*, p. 12 (RX 3).

[22] *What the AMA Dues Dollar Does*, introductory statement by James H. Sammons, Executive Vice President AMA (RX 3).

lected by the AMA is useful for understanding trends, such as in the number of physicians. However, such data is also useful for securing favorable legislation on behalf of physicians (i.e., physician/population ratios are used to indicate whether there is a shortage of physicians, productivity changes, location of physicians, etc.). For example, the AMA collects ". . . data on . . . fees . . ., expenses and incomes, hours practiced . . ."[23] Further, "because the AMA conducts an ongoing program of basic economic research, it can enter various socioeconomic debates to assert a *stronger* position than would otherwise be possible. No one at the AMA was happy over the controls imposed on physicians by the Economic Stabilization Act from late 1971 to early 1974. *But without the data the AMA was able to bring to the many meetings of the Cost of Living Council, the controls on fees would have undoubtedly hurt more and lasted longer than in fact they did*" (emphasis added).[24]

Given the AMA's own statement of the importance of its data collection and research activities to the economic benefit of its physicians, it is inaccurate to exclude *all* such expenditures from the economic benefit classification.

3. *Public and Media Relations*

The AMA's public relations activities were estimated at $877,000 for 1977. Public Information on Health was budgeted for an additional $535,000.[25] They were apparently classified in the Sturdivant report as not promoting physicians' economic interests. These activities are undertaken by the AMA to promote its viewpoint on health care issues to the public and to decisionmakers to help secure legisla-

[23] *Ibid*, p. 9 (RX 3).

[24] *Ibid.* (RX 3)

[25] *American Medical Association 1977 Budget*, pp. 20 and 17 (RX 567).

tion that is of economic benefit to its members. For example, ". . . the AMA public relations function includes helping medicine participate in the public dialogue on health care issues. The PR staff counters critical articles such as the five-part New York Times series last winter, on incompetent medical care and an inaccurate Congressional report on unnecessary surgery.[26]

The above critical reports on unnecessary surgery and on incompetent physicians could have led to stronger controls on quality being placed on physicians and monitoring of such measures by non-physicians. Quality control programs such as PSROs can adversely affect physicians' incomes. Thus, these public relations activities are important in defusing or modifying legislation that is potentially harmful to physicians' incomes. Again, to completely exclude all these public relation activities as though they do not provide any economic benefits is misleading.

The above are examples of some of the activities that provide more than one type of benefit to the AMA's members. Even a number of the "scientific" projects, such as information on computers and library services, can be classified as providing certain economic benefits to physicians in that they increase physicians' productivity, hence their incomes. Also, scientific journals such as *JAMA* carry "help wanted ads" which provide some economic benefit to physicians. All of the above activities and others are classified in the Sturdivant report as providing no economic benefit to physicians. This results in an understatement of economic benefits when the budget approach is applied to the AMA's activities.

C. *What Is the Relevant Expenditure Base upon Which to Calculate the AMA's Commitment to Serving Its Members' Economic Interests?*

1. *Members' Dues as the Relevant Expenditure Base*

If one wants to show that the AMA spends a very small percentage of its budget on economic activities, then the

[26] *What the AMA Dues Dollar Does*, p. 6 (RX 3)

expenditure base should be made as large as possible. A given dollar amount spent on economic activities becomes a small percentage when the expenditure base is increased. The approach used in the Sturdivant report to calculate the percentage of AMA activities that are classified as economic is to include in the expenditure base *all* expenditures on publications and on projects that are funded from grants and from other sources.

However, where the question is the extent to which an association is organized for the profit of its members, the relevant expenditure base is the income the organization receives in dues and assessments from its members. This is because the crucial indicator of a membership organization's relationship *to its members* is the ends to which it devotes the funds supplied *by its members* for the privilege of membership. This is, in fact, the approach taken by the AMA to convince its members to contribute their special dues assessment. In extolling the benefits that the AMA provides its members, it does not discuss the publication of its scientific journals; instead, the emphasis is clearly on the economic benefits provided to physicians.[27] The AMA recognizes that whether or not physicians join the AMA depends on their perception of the economic benefits of membership in relation to the costs of belonging. The AMA's estimated revenue from non-dues sources was $20 million in 1977.[28] The effect of including all these revenues in the expenditure base used in the Sturdivant report is to increase inappropriately the expenditure base and thereby show a smaller commitment to physicians' economic interests.

Consideration of the AMA's scientific journals helps illustrate the bases of the foregoing analysis. The AMA's advertising and subscription revenues roughly approxi-

[27] American Medical Association, *If You Haven't Paid Your Assessment* . . . (CX 258).

[28] *American Medical Association 1977 Budget*, p. 15 (RX 567).

mate its expenditures for scientific journals.[29] To the extent that the revenues and expenses of these journals are roughly equal, then the physician-members of the AMA are *not* subsidizing such activities with their dues. The publication of these scientific journals can be considered as a separate business and the AMA's expenditures for these publications should be excluded from the relevant expenditure base. The AMA also receives payment for other activities it is engaged in, and these revenues and expenditures should also be excluded from the expenditure base. For example, the AMA's participation in "Health and Medical Care in Jails" (A1, $509,961) is partly funded by the Law Enforcement Assistance Agency of the Justice Department.[30] Ideally, one should be able to identify the source of revenues for each of the different AMA activities. Unfortunately, in the Sturdivant report all expenditure and revenue data are lumped together. It is not possible to determine how the AMA spends its *dues* dollars even though that would be the best budgetary approach for calculating the extent of the AMA's commitment to its members' economic interests.

[29] For 1977, advertising revenues were estimated at $10.187 million. *Ibid.* Subscriptions earned $2.114 million and sales from books and pamphlets earned $.545 million for total estimated revenue in 1977 of $12.846 million. *Ibid.* Expenditures for scientific publications (Category A2) were estimated at $13. million. *Ibid.* It would thus appear that the estimated revenues of $12.346 million approximately equal the expenditures for scientific publications. In 1975, the AMA's advertising, sales, and subscriptions revenues substantially exceeded its expenditures on scientific publications. *American Medical Association Budget Summary for the Fiscal Year Ending November 30, 1975*, pp. 9, 12-13 (RX 568). It should be noted that the Sturdivant report incorrectly classifies "Research, Bibliography, and Photocopy Services for Physicians" ($156,472) as an expenditure under scientific publications which raises the expenditure base over the revenue received from scientific publications.

[30] *What the AMA Dues Dollar Does*, p. 7 (RX 3).

2. *Treatment of Resources Placed into Reserves*

In 1977, the AMA had estimated revenues of $57.8 million. $11.6 million was not spent but was placed into the association's reserves.[31] These reserve funds should be excluded from the relevant expenditure base (and were excluded in the Sturdivant report which used an expenditure base of $45 million). From the starting expenditure base of dues income, it is proper, therefore, to subtract the portion of the $11.6 million in reserves which was derived from dues money.

3. *Basis for Recalculation*[32]

The AMA's total revenues in 1977 were $57.8 million. Of this $57.8 million, $56.9 million was received in dues income, $12.8 million in advertising, subscriptions, and sales of publications, and $8.1 million from other sources. As is discussed above, the $12.8 million in publications income should be excluded from the relevant expenditure base. Subtracting $12.8 million from $57.8 million leaves $45 million in 1977 revenues.

$11.6 million of the $45 million was not spent, but was placed into reserves. It is logical to assume that proportionate amounts of dues money and money from other sources were placed into reserves.[33] Since $11.6 million is one fourth of $45 million, I will estimate that one fourth of the $56.9 million in dues and one fourth of the remaining $8.1 million were placed into reserves.

Subtracting one fourth of $56.9 million leaves $27.6 million in dues income spent in 1977. Subtracting one fourth of the $8.1 million leaves $6.1 million from other sources

[31] *Ibid.* (RX 3).

[32] All figures in this subsection are drawn from the *American Medical Association 1977 Budget* (RX 567).

[33] I have allocated no funds from the scientific journals income to reserves, because I view them as self-supporting projects which are budgeted so as to pay for themselves.

that was actually spent in 1977. Since the AMA's actual expenditures of its dues income is, in my opinion, the appropriate base to examine in order to determine the share or percentage devoted to furthering physicians' economic interests, the relevant expenditure base should be $27.6 million.

There is a problem with this figure, however. If dues income only is used as the expenditure base, then only those activities yielding economic benefits that were funded with dues money should be included when a percentage is calculated. However, the project request forms do not indicate whether each particular project was funded by dues or non-dues income. So it might be unfair to use dues income alone as the relevant expenditure base.

So, an alternate upper limit expenditure base can be set by adding to the $27.6 million in dues the $6.1 million in non-dues income expended in 1977. This yields an alternate expenditure base of $33.7 million.

IV. RECALCULATING THE PERCENT OF THE AMA'S RELEVANT EXPENDITURE BASE THAT PROVIDES ECONOMIC BENEFITS TO AMA MEMBERS

As discussed above, the budget approach used in the Sturdivant report is not very reliable, and it is impossible to allocate expenditures accurately when activities provide both economic and non-economic benefits. Thus, any allocation system to determine economic benefit resulting from a budget approach is subject to severe limitations, if it can be used at all, and will tend to greatly understate the extent of economic benefits. However, assuming that some quantitative analysis is desired, a recalculation of the AMA expenditures that provide an economic benefit was undertaken.

Economic benefits, as a percent of the AMA's budget, is recalculated according to the two expenditure bases discussed above, $27.6 million and $33.7 million.

A. *Activities That Provide an Economic Benefit*

The activities cited in the Sturdivant report as providing an economic benefit were projects listed in Categories B and C.

Category B	=	$1,219,400[34]
Category C	=	$1,449,750
TOTAL	=	$2,669,150[35]

In addition to the above activities, I have reclassified a number of other activities as providing an economic benefit. This reclassification was based on the description in the project request forms and upon my own background and experience in the field of medical care. The types of projects that were reclassified are of the types explained earlier in this analysis. A list of the reclassified projects is attached to this analysis as the Appendix. The expenditures for these reclassified projects total $9,161,325. Adding these expenditures to Categories B and C in the Sturdivant report results in expenditures of $11.8 million that provide economic benefits.[36] *The expenditures of $11.8 million that are believed*

[34] Includes $722,695, subsequently included and explained in a footnote at the bottom of page 8 of the Sturdivant report.

[35] This figure is 5.3 percent of the expenditure base used in the Sturdivant report. It amounts to 9.7 percent and 7.9 percent, respectively, of the two expenditure bases noted above.

[36] Obviously not everyone will agree with the list of projects that were reclassified as providing an economic benefit. For example, the *American Medical News* and *Impact* were listed as providing an economic benefit. In addition to the numerous advertisements directed at physicians on, for example, construction of medical office buildings, there is a heavy economic and political content to the news articles. Also, the importance of the *American Medical News* in informing the membership and making them sensitive to various political issues was quoted in *What the AMA Dues Dollar Does*, p. 12.

to provide an economic benefit represent 43 percent of the $27.6 million expenditure base and 35 percent of the $33.7 million expenditure base.

It should be noted that examples were presented earlier of some of the AMA's activities that confer a heavy economic benefit, such as Data Collection, and Public and Media Relations. Expenditures in these two categories alone were approximately $5 million in 1977. To stay on the conservative side, the vast majority of these expenditures are totally excluded from classification as providing an economic benefit. Similarly, of the $11.8 million in the A8 Organizational Maintenance and Operations Category, I have retained over $6.7 million in the non-economic benefits category. Of this $6.7 million in Category A8 and the $4 million for Data Collection and Public and Media Relations that I have classified as non-economic benefit,[37] I believe a fraction, perhaps 30 percent, amounting to over $5 million, could also have been fairly placed in the economic benefits category. To be on the conservative side, however, these projects were not counted as being for the economic benefit of physicians.

V. CONCLUSION

It should be noted once again that the budget approach used in the Sturdivant report for determining that part of the AMA's activities that provides economic benefits to its members is subject to severe limitations. Many economic activities on behalf of the AMA's members are not included in the AMA's budget, and a one year budget analysis is insufficient for a reliable analysis. The main problem in

[37] As shown in the Appendix, I have classified approximately $1 million in Data Collection Projects of the $5 million in Data Collections and Public and Media Relations projects as providing economic benefits to the AMA's members.

the Sturdivant report's actual implementation of the budget approach is its determination of which activities actually provide economic benefits. The unduly narrow view of economic benefits used in the Sturdivant report would, I believe, be disputed by scholars familiar with the field of medical care. There is also the major problem of separating the economic from the non-economic benefits within any given AMA activity. Finally, there is the difficulty of calculating the appropriate expenditure base to be used to determine that fraction of the AMA's activities that provides an economic benefit.

The combined effect of all of these problems with the budget approach is that any estimate of economic activities based on this approach is likely to be understated. It is not a useful approach for determining whether or not the AMA acts in the economic interests of its members. Acknowledging these limitations in the budget approach, it is my conservative estimate that between 35 and 45 percent of the appropriate base of the AMA's expenditures was spent on projects providing substantial economic benefits to physicians.

APPENDIX
LIST OF RECLASSIFIED PROJECTS

Sturdivant Report Category	Project	1977 Budget
A_3	Review and Analysis of Legislation Affecting Health Manpower	$ 48,424
A_3	Information, Analysis and Consultation on Health Manpower	68,281
A_3	Health Care Financing—Policy and Information	16,406
A_3	Alternative Health Care Financing Systems	10,471
A_4	Memberships and Grants—Health Agencies	58,040
A_5	Analyses of Malpractice and Professional Liability	56,831
A_5	Commission on the Cost of Medical Care	293,705
A_5	Analysis of Institutions Affecting Medical Care Delivery	10,338
A_5	Distributional Characteristics of Health Manpower	60,998
A_5	Analysis of Physician Mobility	88,833
A_5	Physician Distribution and Medical Licensure	96,756
A_5	FMG Book	62,931
A_5	Health Service Area and State Distribution of Physicians	75,521
A_5	Feasibility Study for Modeling a Health Care Delivery System	1,446
A_5	Medical Socioeconomic Research Sources—Research Services and Support	41,982
A_5	Council on Medical Services	148,864
A_6	Ad Hoc Committee on PSRO	56,467
A_6	Speakers and Leadership Training	107,063

Sturdivant Report Category	Project		1977 Budget
A_6	PSRO Activities		$ 73,897
A_7	Government Interface:		
	—Liaison with Government Agencies	$189,228	
	—Congressional Liaison	499,059	
	—Legislative Roundup	102,456	
	—Monitor and Analyze Health Legislation and Regulations	236,430	
	—Preparation of Statements and Briefing Activities	158,759	
	—AMA Health Legislation Proposals	51,428	
	—Council on Legislation	155,530	
	—Coalitions	42,474	
	—State Legislation and Regulation Activities	163,456	
	—National Speakers Bureau	23,606	
	—Analysis of and Regulation Initiatives Affecting Health Care Providers	27,984	
			1,630,410
A_8	American Medical News		3,051,520
A_8	Impact		622,227
A_8	Federation Liaison		581,985
A_8	Membership Opinion Survey		86,658
A_8	Citation		109,640
A_8	Policy Issue Papers		41,605
A_8	Legal Services to the Profession		469,878
D	Physicians Placement Service		269,764
D	Services to AMPAC		900,382
	TOTAL OF RECLASSIFIED PROJECTS		$9,161,323

RNHX 109—Excerpts From "Primary Medical Care Directory, New Haven 1976"

FORWORD

This Directory contains the names of medical practitioners and health centers in New Haven, offering primary care. It does not include specialists other than those offering primary care. The names of such other specialists can be obtained from one's personal (primary care) physician.

The list contains only the names of those physicians who made information available. It has been compiled jointly by the New Haven Medical Association and the New Haven Health Department.

Elliot S. Brand, M.D.	Hans H. Neumann, M.D.
President	Medical Director
New Haven Medical Assoc.	New Haven Health Dept.

CONTENTS

	Page
Family Practice	1
Internal Medicine	12
Pediatricians	30
Health Centers and Hospital Primary Care Centers	38

FAMILY PRACTICE

AMATRUDA, Frank G., M.D. Tel. 865-1496
459 Orange Street Downtown
Family Practice
HOUR: 9:00 to 10:30 A.M. & 1:00 to 2:30 P.M.
Hosp. Affiliation: Yale New Haven Hospital
Hospital of St. Raphael
Grad: Yale U.-'23
Medicare Assignment: No
Medicaid: No
BASIC FEES (1976): 1st visit—$15.00
Follow-up visit—$10.00
(Fees may vary according to circumstances)

CELENTANO, Luca E., M.D. Tel: 624-0103
442 Elm Street Downtown
Family Practice
HOURS: By appointment
Hosp. Affiliation: Yale New Haven Hospital
Hospital of St. Raphael
Grad: Hahnemann—'30
Medicare Assignment: Yes
Medicaid Patients: Yes
BASIC FEES (1976): 1st visit—$35.00
Follow-up visit—$15.00
(Fees may vary according to circumstances)

COLE, Ransey G., M.D. Tel. 624-4769
432 Dixwell Ave. Dixwell-Newhallville
Family Practice
HOURS: 9:30 to 12:30 P.M. & 3:00 to 5:00 P.M.
(No Wednesdays or Saturdays)

Hosp. Affiliation: Yale New Haven Hospital
Hospital of St. Raphael
(Hosp. courtesy staff)
Grad: Meharry—'44
Medicare Assignment: Yes
Medicaid Patients: Yes
BASIC FEES (1976): 1st visit—$15.00
Follow-up visit—$10.00
(Fees may vary according to circumstances)

COUSINS, Marvin L., M.D. Tel: 865-5111
1308 Chapel St. Near Hosp. St. Raph.
Family Practice
HOURS: 9:00 to 5 P.M.-Mon., Tues., Thurs., Fri.
9:00 to 12:30 P.M.-Wednesday & Saturday
Hosp. Affiliation: Yale New Haven Hospital
Grad: Vermont—'52
Medicare Assignment: No
Medicaid Patients: No
BASIC FEES (1976): 1st visit—$30.00
Follow-up visit—$17.00
(Fees may vary according to circumstances)

CUSANELLI, Gabriel N., M.D. Tel: 562-9252
235 Bishop Street Downtown
Family Practice
HOURS: 1:00 to 4:30 P.M.-Mon., Tues., Thurs., Fri.
10:00 to 12:00 P.M.-Saturday
Hosp. Affiliation: Yale New Haven Hospital
Hospital of St. Raphael
Grad: Long Island U.—'46
Medicare Assignment: Yes
Medicaid Patients: Yes
BASIC FEES (1976): 1st visit—$8 to $12.00 (routine)
Follow-up visit—$8 to $10.00
(Fee may vary according to circumstances)

FASANO, Leonard A., M.D. Tel: 387-2569
980 Whalley Ave. Westville
Family Practice-including children over 13 years
HOURS: 8:00 A.M. to 5:00 P.M.-Mon. through Fri.
Hosp. Affiliation: Yale New Haven Hospital
Hospital of St. Raphael
Grad: New York Med. Coll.—1955
Medicare Assignment: No
Medicaid Patients: No Title XIX: No
BASIC FEES (1976): 1st visit—$16.00
Follow-up visit—$13.00
(Fee may vary according to circumstances)

HEALTH CENTERS AND HOSPITAL PRIMARY CARE CENTERS

THE COMMUNITY HEALTH CARE CENTER PLAN
150 Sargent Drive (Long Wharf area)
Tel: 787-3141
HOURS: 9 A.M. to 5:15 P.M.—Mon., Tues., Thurs., Fri.
12:30 to 8:15 P.M.—Tuesday
Family Practice, Internal Medicine, Pediatrics
Medicare: Yes
Medicaid: Yes
FEES: Varies according to circumstances*
* CHCP is a prepaid group practice plan. Membership is through employers or individual contracts.
Health care service provided primarily to plan's enrollees.

FAIR HAVEN COMMUNITY HEALTH CENTER
374 Grand Ave. (Fair Haven residents only)
Tel: 777-3704

HOURS:
6 to 9 P.M.—Gen'l. Med.—Mon., Tues., Thurs.
6 to 9 P.M.—Women's Cl. & Fam. Plan.—Wed.
3 to 5 P.M.—Prenatal C.—Mon., Tues.
Medicare: Yes Medicaid: Yes
Hosp. Affiliation: Yale New Haven Hospital
FEES (1976): Sliding scale—varies according to circumstances.

HILL HEALTH CENTER Tel: 432-4400
428 Columbus Ave. (Hill area residents only)
HOURS: 9 A.M. to 8:30 P.M.—Mon., Tues., Thurs.
9 A.M. to 4:30 P.M.—Wed., and Fri.
9 A.M. to 12:00 P.M.—Saturday
Hosp. Affiliation: Yale New Haven Hospital
Family Practice, Internal Medicine, Pediatrics
Medicare: Yes
Medicaid: Yes
FEES (1976): Sliding scale—varies according to circumstances.

HILL HEALTH CENTER ELDERLY SATELLITE CLINIC
904 Howard Ave.
Tel: 432-4485
Services available to ALL NEW HAVEN area elderly 60 yrs. and over.
HOURS: 9 A.M. to 4:30 P.M.—Mon. through Fri.
Medicare: Yes
Medicaid: Yes
FEES (1976): Sliding scale—varies according to circumstances.

HILL WEST ROCK COMMUNITY HEALTH CENTER
34 Level St. (former Springside Conv. Hosp.)
Tel: 389-6541

HOURS: 8:45 A.M. to 4:30 P.M.—Mon. through Fri.
Hosp. Affiliation: Yale New Haven Hospital
Family Practice, Internal Medicine, Pediatrics
Medicare: Yes
Medicaid: Yes
FEES (1976): Sliding scale—varies according to circumstances.

HOSPITAL OF ST. RAPHAEL PRIMARY CARE CENTER
116 Sherman Ave.
Tel: 772-3900, Ext. 516
HOURS: 8 A.M. to 4:30 P.M.
Family Practice, Internal Medicine, Pediatrics
Medicare: Yes
Medicaid: Yes
FEES (1976): Sliding scale

YALE NEW HAVEN HOSPITAL PRIMARY CARE CENTER

789 Howard Ave. Hill area
Tel: 436-3660
HOURS: 8 A.M. to 4:30 P.M.—Mon. through Fri.
5 P.M. to 8 P.M.—Wednesday (Med. Cl.)
Family Practice, Internal Medicine, Pediatrics
Medicare: Yes
Medicaid: Yes
FEES: Initial visit—Flat rate—$24.00
Return visit—based on financial status and family size.

RNHX 149—Excerpts From Primary Medical Care Directory, Revised Edition

FOREWORD

The revised edition of this Directory lists medical practitioners and health centers in New Haven which offers primary care. It does not include specialists other than those offering primary care since the names of such other specialists can be obtained from one's personal or family doctor (primary care physician).

The Directory contains only the names of those physicians who provide information. It is co-sponsored by the New Haven Medical Association and the New Haven Health Department.

John J. Milici, M.D.
New Haven Medical Association
Hans H. Neumann, M.D.
New Haven Health Department
Mayor's Committee on the Elderly

CONTENTS

	Page
Family Practice	1
Internal Medicine	13
Pediatricians	31
Health Centers and Hospital Primary Care Centers	41

FAMILY PRACTICE

CELENTANO, Luca E., M.D.
442 Elm St. (Downtown)
Tel: 624-0103
Family Practice
HOURS: By appointment
Hosp. affiliation: Yale New Haven Hosp.
Hosp. of St. Raphael
Grad: Hahnemann—'30
Medicare: Yes
Medicaid: Yes
BASIC FEES (1978): 1st visit—$35.00
Follow-up visit—$15.00
(Fees may vary according to circumstances)

COLE, Ransey G., M.D.
432 Dixwell Ave. (Newhallville)
Tel: 624-4769
Family Practice
HOURS: 9:30 to 12:30 & 3 P.M. to 5 P.M.
Wed.: 9 to 12 Sat.: 9 to 12
Hosp. affiliation: Yale New Haven Hosp.
Hosp. of St. Raphael
Grad: Meharry—'44
Medicare: Yes
Medicaid: Yes
BASIC FEES (1978): 1st visit—$15.00
Follow-up visit—$10.00
(Fees may vary according to circumstances)

COUSINS, Marvin L., M.D.
1308 Chapel St. (near St. Raphael Hospital)
Tel: 865-5111
Family Practice—Chapel Medical Group
HOURS: 9:00 to 5:00 P.M.—Mon., Tues., Thurs., Fri.
9:00 to 12:30 P.M.—Wed. & Sat.
Hosp. Affiliation: Yale New Haven Hospital
Grad: Vermont—'52
Medicare Assignment: No
Medicaid Patients: No
BASIC FEES (1978): 1st visit—$35.00
Follow-up visit—$18.00
(Fees may vary according to circumstances)

CUSANELLI, Gabriel N., M.D.
235 Bishop Street (Downtown)
Tel: 562-9252
Family Practice
HOURS: 1:00 to 4:30 P.M.—Mon., Tues., Thurs., Fri.
10:00 to 12:00 P.M.—Saturday
Hosp. Affiliation: Yale New Haven Hospital
Hospital of St. Raphael
Grad: Long Island U—'46
Medicare Assignment: Yes
Medicaid Patients: Yes
BASIC FEES (1978): 1st visit—$10-12 (routine)
Follow-up visit—$10.00
(Fees may vary according to circumstances)

HEALTH CENTERS AND HOSPITAL PRIMARY CARE CENTERS

THE COMMUNITY HEALTH CARE PLAN

150 Sargent Drive (Long Wharf area)
Tel: 787-3141
HOURS: 9 A.M. to 5:15 P.M.—Mon., Wed., Thurs., Fri.
12:30 to 8:15 P.M.—Tuesday
Family Practice, Internal Med., Pediatrics, and various other medical specialties.
Medicare: Yes
Medicaid: Yes
FEES: Vary according to circumstances*
* (CHCP is a prepaid group practice plan. Membership is through employers or individual contracts.)
Health care service is provided primarily to plan's enrollees.

FAIR HAVEN COMMUNITY HEALTH CENTER

374 Grand Ave. (Fair Haven residents only)
Tel: 777-7411
HOURS: By appointment 9 A.M. to 5 P.M. every weekday for general medical services. Special clinics for Pre-Natal care, Family Planning, Dermatology, Gynecology. Walk-in clinics Mon., Tues., Thurs.; 6 P.M. to 8 P.M.
Medicare: Yes Medicaid: Yes
FEES: Sliding scale—varies according to financial situation.

HILL HEALTH CENTER

428 Columbus Ave. (Hill area residents only)
Tel: 432-4400
HOURS: 9 A.M. to 8:30 P.M.; Mon., Tues., Thurs.
9 A.M. to 4:30 P.M.; Wed., Fri.
9 A.M. to 12:00 P.M.; Saturday

Hosp. affiliation: Yale New Haven Hosp.
Family Planning, Internal Med., Pediatrics,
Obstetrics and Gynecology.
Medicare: Yes
Medicaid: Yes
FEES: Sliding scale—varies according to circumstances.

HILL HEALTH CENTER ELDERLY
SATELLITE CLINIC
904 Howard Ave.
Tel: 432-4485
Services available to all NEW HAVEN AREA
elderly—60 yrs. and over.
Hosp. affiliation: Yale New Haven Hosp.
Medicare: Yes
Medicaid: Yes
FEES: Sliding scale—varies according to circumstances.

HILL WEST ROCK COMMUNITY HEALTH CENTER
34 Level St. (formerly Springside Conv. Hosp.)
Tel: 389-6541
HOURS: 8:45 A.M. to 4:30 P.M.; Mon. through Fri.
Wednesday evenings until 7:30.
24 hour on call service.
Adult medicine, Internal Med., Pediatrics,
Obstetrics and Gynecology.
Medicare: Yes
Medicaid: No
FEES: Fee for service—income and family size
taken into account.

HOSPITAL OF ST. RAPHAEL
PRIMARY CARE CENTER
116 Sherman Ave.
Tel: 789-3527
HOURS: 8 A.M. to 3:30 P.M. (By app't only)

Family Practice, Internal Med., Pediatrics,
and all who request services.
Medicare: Yes
Medicaid: Yes
FEES: Sliding scale—services available to all
who request or require them.

YALE NEW HAVEN HOSPITAL
PRIMARY CARE CENTER
789 Howard Ave.
Tel: 436-3660
HOURS: 8 A.M. to 4:30 P.M.; Mon. through Fri.
5 P.M. to 8:00 P.M.; Wed.
(Med. Clinics and Pediatrics)
Family Practice, Internal Med., Pediatrics.
Medicare: Yes
Medicaid: Yes
FEES: Initial visit (flat rate)—$26.50
Return visit—Based on family size
and financial status.

RX 526—Excerpts From "The Doctors Directory (1977-1978) Tucson-Green Valley"

Guild Statement

This medical directory has been compiled and published at cost by the Professional Guild of Arizona as a community service to help individuals and families find appropriate medical care. The information contained within was obtained by questionnaires sent to all physicians, D.O. or M.D., in the county. Included are all physicians who desired to be listed. The summary is intended to outline availability, training and scope of practice. The information is accurate to the best of our knowledge as of December, 1976. The charges described may not apply if a new fee schedule has been adopted subsequent to that date or if extra time or studies are needed.

© June 1977

Professional Guild of Arizona
899 N. Wilmot B-1
Tucson, Arizona 85711

Table of Contents

Table of Contents 1–2
Definition of Board 3
Description of Specialties 3–5
Hospital Abbreviations 6
East 7–39
- Allergy 7
- Anesthesiology 8
- Dermatology 8
- Family Practice 9–11
- General Surgery 11–13
- Internal Medicine 13–19
- Neurology & Neurosurgery 19
- Nuclear Medicine 20
- Obstetrics & Gynecology 20–23
- Ophthalmology 23–25
- Orthopedic Surgery 25–28
- Otolarnygology 28–30
- Pathology 30
- Pediatrics 31–32
- Physical Medicine & Rehabilitation 32
- Plastic Surgery 33
- Psychiatry 33–35
- Radiology 35
- Thoracic Surgery 36
- Urology 36–39

Map 40–41
Central 42–72
- Allergy 42
- Anesthesiology 42
- Colon & Rectal Surgery 42
- Dermatology 43
- Family Practice 43–45
- General Surgery 45–47
- Internal Medicine 47–53
- Neurology & Neurosurgery 54
- Obstetrics & Gynecology 54–57

Table of Contents

Central
- Ophthalmology 57–60
- Otolarnygology 60–61
- Pathology 61
- Pediatrics 62–65
- Physical Medicine & Rehabilitation 65
- Psychiatry 65–67
- Radiology 67–69
- Urology 69–70

West 71–81
- Allergy 71–72
- Family Practice 72–74
- General Surgery 74–75
- Internal Medicine 75–76
- Neurology & Neurosurgery 77
- Ophthalmology 77
- Otolarnygology 77
- Orthopedic Surgery 78
- Pathology 78–79
- Pediatrics 79
- Psychiatry 79–80
- Urology 81

Green Valley 82
- Family Practice 82
- Ophthalmology 82
- Specialty Clinics 82
  - Allergy 82
  - General Surgery 82
  - Internal Medicine 82
  - Pulmonary Diseases 82
  - Otolarnygology 82
  - Urology 82

Index 85–87
Emergency Information ..... Back Cover

Definition of Board

BOARD CERTIFIED: The doctor has completed an approved course of training in his or her specialty and has passed a comprehensive examination and has been declared competent to practice in this field.

BOARD ELIGIBLE: The doctor has completed the approved course of training in his or her specialty but has not as yet been certified by examination.

Description of Specialties

Anesthesia: A doctor who by various techniques renders you insensible to pain during surgery. He also assists other doctors in the diagnosis and treatment of pain.

Clinical Allergy and Immunology: Diagnosis and treatment of hay fever, chronic nasal congestion, asthma, hives and drug reactions utilizing skin tests and allergic history. Therapy by appropriate medications and injections in all age groups.

Colon and Rectal Surgeon: A surgical doctor who limits his practice to the diagnosis and surgical treatment of the diseased or otherwise abnormal colon, rectum and anus.

Dermatology: Dermatology includes the diagnosis and treatment of all diseases of the skin including rashes, acne, warts, moles, and skin cancers. Dermatologists are also trained in treating diseases of the hair, nails and mucous membranes. All ages and both sexes.

Family Practice: Offering comprehensive care to patients of all ages, these physicians possess a large fund of medical knowledge enabling them to diagnose and treat a wide range of simple and complicated medical problems. They serve as primary physicians as the patient enters the modern day health delivery system. Individual practitioners seldom limit their practice to the office, but usually admit and then follow their patients to the hospital where they formulate treatment plans, call upon appropriate specialists for services, assist at major surgeries, perform minor surgeries themselves and manage all but the most complicated of cases. In many instances these doctors serve as the focal point in the medical management of the patient.

Family practitioners deliver babies, preferring to carry out the pre-natal and post-partum care of mothers and new born care of children so as to avoid a break in the continuity of care of these new families.

These doctors make house calls when indicated, or may direct their patients to hospital emergency rooms when urgent and there assume their care.

General Surgery: The specialty of surgery usually requires four years of graduate training beyond medical school and internship.

Certification is obtained by written and oral examination by the American Board of Surgery. General surgeons treat a wide spectrum of problems, including gall bladder disease, appendicitis, hernia, thyroid, breast cancer, skin lesions, hemorrhoids, stomach ulcers, gastrointestinal tract problems and sometimes blocked blood vessels and accident surgery.

Internal Medicine: Internal Medicine is the branch of medicine that specializes in diagnosis of internal disorders and treatment with medicine, diet or exercise.

The subspecialty branches include: cardiology which deals with diseases of heart and blood vessels; gastroenterology which deals with disorders of the digestive organs, hematology-oncology which deals with blood disorders and cancer treatment; infectious disease which deals with difficult or unusual infections; nephrology which deals with non-surgical kidney disorders; pulmonary which deals with lung disorders; and rheumatology which deals with joint and muscle disorders.

Neurology/Neurosurgery: Neurology/Neurosurgery—diagnosis and treatment of diseases of the nervous system which includes brain, spinal cord, peripheral nerve, muscle, and skeletal disorders.

Nuclear Medicine: A doctor who aids other doctors in diagnosing ills by injecting small amounts of radioactive materials to picture various organs. Ultrasound is also used for this purpose. These procedures are essentially risk free, pain free and without side effects.

Obstetrics-Gynecology: The care of the female during pregnancy. Also, medical and surgical treatment of female genital organs (vagina, uterus, tubes and ovaries) or reproductive problems.

Ophthalmology: The care of the entire visual system utilizing glasses, contact lenses, medicine and surgery.

Orthopedic Surgery: The care of problems of bones, joints, muscles and associated structures in all ages.

Otolaryngology: This specialty includes the medical and surgical treatment for disorders of the ear, nose, throat and neck in children and adults. This includes tumor surgery of the head and neck, microsurgery of the ear for hearing loss, cosmetic facial surgery, repair of facial fractures and examination of the air and food passages for foreign body and diagnosis.

Pathology: A pathologist is an expert in laboratory medicine and studies disease as found in tissues and fluids of the body. Pathologists have often been called "a doctor's doctor" as they perform and interpret tests on these fluids and tissues for your doctor. They supervise the laboratory and insure that the procedures used are the most reliable, accurate and economical. Some of the things they do include examination of tissues under the microscope for cancer (including frozen sections and autopsies), pap smears, blood and urine tests and tests for bacteria (germs).

Pediatrician: A doctor who cares for medical disease of infants, children and adolescents to age 21.

Physical Medicine and Rehabilitation: Physicians who practice Physical Medicine and Rehabilitation care for people with back, neck and other pain problems, along with those who have suffered disabling conditions, such as stroke, spinal cord injury or brain injury. Following diagnosis, which often includes electromyography, patients are treated with medication and therapy modalities such as speech therapy, occupational therapy and physical therapy. Acupuncture is also used as a modality in the treatment of pain.

Plastic Surgery: Cosmetic Surgery; reconstruction following injury; cancers of the skin, head and neck; birth deformities; fractures of facial bones; hand surgery; burns. All ages, men and women.

Preventive Medicine: This specialty is supported by one to three years of postgraduate training and certification by examination. Preventive Medicine is concerned with evaluating and treating disease processes with special attention to their prevention.

Psychiatry: Psychiatry is the medical specialty that investigates, treats and attempts to prevent disorders of the mind. These disorders may involve impairment of brain tissue or impairment of the personality in relating to itself and others. The degree of disorder can vary from normal (to rule out psychiatric illness) to very abnormal (though contrary to popular myth, most of his patients are not "crazy"). The treatment methods range through a variety of vocal and/or physical techniques depending upon which the specialist determines is most suitable for the patient's needs. The chances of recovery, as with other medical illness often depends upon early detection with prompt, appropriate treatment and follow-up.

Radiology: Radiology is a branch of medicine dealing with various types of radiation for both diagnosis and treatment.

Diagnostic Radiology includes other imagery modalities in addition to x-ray, such as ultra-sound, nuclear medicine, thermography and computerized scanners.

Therapeutic Radiology deals with the treatment of disease with radiation and pharmaceutical agents.

Thoracic Surgery: The surgical treatment of problems related to the heart, lungs and esophagus including bronchoscopy, pulmonary resection, heart surgery, esophageal surgery and repair of esophageal hiatus hernia. Surgical treatment of valley fever, tuberculosis and lung cancer. Patients of all ages, diagnostic and therapeutic bronchoscopy and esophagoscopy with removal of foreign bodies.

Urology: Urology is the care of urinary problems, kidneys, bladder, prostate and male organs. Men and women. Adults and children. Diagnosis and medical and surgical treatment.

Hospital Abbreviations

AMC	Arizona Medical Center (University Hospital)
KCH	Kino Community Hospital
PVH	Palo Verde Hospital (Psychiatric)
SJH	St. Joseph's Hospital
SMH	St. Mary's Hospital
TGH	Tucson General Hospital (Osteopathic)
TMC	Tucson Medical Center
VAH	Veteran's Administration Hospital
WPH	Wilmot Psychiatric Hospital

EAST

Bernard Dickstein, M.D.

Allergy
Adults, Adolescents, Children
Med. School: Univ. of Michigan 1933
Spec. Training: Northwestern Univ. 1939-41
Certified: American Board of Allergy-Immunology 1966
Hosp: SJH, TMC, KCH

601 N. Wilmot 296-7101
Office: Mon., Tues., Thurs., Fri. 8:30 a.m.-5:00 p.m., Wed., Sat. 8:30 a.m.-Noon
Spanish Spoken: Well.
Bus: Wilmot & 5th St. (In front)
Charges: Initial office visit $50
Routine office visit $10-$15
Special allergy tests $100

L. Winston Martin, M.D.

Allergy
Adults, Adolescents, Children (Above 5)
Med. School: Univ. of Tennessee 1962
Spec. Training: Internal Med., Tripler Army Hosp. 1964-67
Allergy & Immunology, Univ. of Colorado Med. Center 1970-71
Certified: Internal Med. 1968
Allergy & Immunology 1974
Hosp: SJH, TMC

5200 E. Grant Rd., Suite 604 795-1185
Office: Mon. thru Sat. 8:00 a.m.-5:00 p.m.
Spanish Spoken: None.
Bus: Grant & Beverly (100 yards)
Charges: Initial Office visit $45
Routine office visit $12
Skin testing $90

William E. Miller, M.D.

Allergy
Adults, Adolescents, Children
Med. School: Utah 1956
Spec. Training: Southwestern 1957-61
Certified: American Board of Allergy & Immunology 1971
Hosp: SJH, TMC

601 N. Wilmot, Suite 119 296-7101
Also 4717 N. First Ave. 888-0901
Office: Mon. Tues. Thurs. Fri. 8:30 am-Noon, 2:00 p.m.-5:00 p.m.
Wed., Sat. 8:30 a.m.-Noon
Spanish Spoken: Well.
Bus: Wilmot & 5th St. (1 Block)
Charges: Initial office visit, complete allergy evaluation $150
Routine office visit $10

Reuben G. Wagelie, M.D.

Allergy
Adults, Adolescents, Children
Med. School: Univ. of the Philippines 1956
Spec. Training: Michael Reese Hosp., Chicago 1956-61
Baylor Univ. College of Med. 1961-62
Certified: Pediatrics 1961
Allergy & Immunology 1972
Hosp: SJH, TMC

601 N. Wilmot 296-7101
Also 4717 N. 1st Ave. 888-0901
Office (East): Mon., Tues., Thurs., Fri. 9:00 a.m.-Noon, 2:00 p.m.-5:00 p.m.
Wed., Sat. 9:00 a.m.-Noon
Office (West): Tues., Wed., Fri. 9:00 a.m.-Noon, 2:00 p.m.-5:30 p.m.
Spanish Spoken: A little.
Bus: Wilmot & 5th St. (1 Block)
Charges: Complete allergy evaluation $150
Office visits $10

Anesthesiology — East

Raymundo J. Esquivel, M.D.

Anesthesiology
Adults, Adolescents, Children
Med. School: Univ. of Nuevo Leon Mexico 1957
Spec. Training: Youngstown Hosp. Assn. 1960-62
Certified: National Board of Anesthesiology
Hosp: SJH, TMC, SMH, KCH

5402 E. Grant Rd., B-8 — 795-7630
Office: Mon. thru Fri. 8:00 a.m.-5:00 p.m.
Spanish Spoken: Well.
Bus: Grant & Beverly

Thomas A. Webster, M.D.

Anesthesiology
Adults, Adolescents, Children
Med. School: Temple Univ. 1967
Spec. Training: Temple Univ. 1968-71
Certified: American Board of Anesthesiology 1972
Hosp: SJH, TMC

5929 E. Pima, Suite A — 298-2349
Spanish Spoken: A little.

Dermatology

David N. Flieger, M.D.

Dermatology
Adults, Adolescents, Children
Med. School: Case Western Reserve 1969
Spec. Training: Case Western Reserve 1970-73
Certified: American Board of Dermatology 1974
Hosp: SJH, TMC, AMC

6542 Carondelet Dr. — 296-6204
Office: Mon. thru Fri. 9:00 a.m.-4:30 p.m.
Sat. 9:00 a.m.-11:45 a.m.
Spanish Spoken: Moderate.
Bus: Wilmot & 5th St. (500 feet)
Charges: Initial office visit $18
Routine office visit $12
Removal of mole $25
Liquid nitrogen treatment of warts & keratoses, depending on No. $12-$30

Ralph A. Lemcke, M.D.

Dermatology
Adults, Adolescents, Children
Med. School: Indiana 1966
Spec. Training: Univ. Hospa. of Cleveland 1969-72
Certified: American Board of Dermatology 1973
Hosp: SJH, TMC

6542 Carondelet Dr. — 296-6204
Office: Mon. thru Fri. 9:00 a.m.-5:00 p.m.
Sat. 9:00 a.m.-Noon
Spanish Spoken: Moderate.
Bus: Wilmot & 5th St. (Same corner)

Richard C. Miller, M.D.

Dermatology
Adults, Adolescents, Children
Med. School: Yale 1958
Spec. Training: Columbia-Presbyterian Medical Center 1962-65
Certified: American Board of Dermatology 1966
Hosp: SJH, TMC, SMH, KCH

5200 E. Grant Rd. — 881-8161
Office: Mon. thru Fri. 9:00 a.m.-5:30 p.m.
Sat. 8:00 a.m.-Noon
Spanish Spoken: Well.
Bus: Grant (Next to office)
Charges: Initial office visit $20
Routine office visit $10
Skin cancer-removal $70
Skin biopsy $10

RX 415—Excerpts From "Physicians Directory for Whatcom County" (Revised Edition, 1976) Fairhaven College

FORWARD

This Directory is designed to introduce the physicians of Whatcom County to you, the medical consumer. The Directory should aid you in choosing a doctor by supplying some of the basic information you would probably want to have in making your choice; at the same time, it should spare doctors and their office staffs from having to answer these questions for each prospective patient. No directory can supply all the information each consumer might consider important. The Directory, therefore, should also serve to remind you that you are entitled to any relevant information concerning the care you are likely to receive. This is true not only when you choose a physician but as part of your ongoing relationship. If you want to know about fees for specific procedures, possible side effects of drugs prescribed, the doctor's choice of hospital etc., it is your right to ask and the physician's acknowledged obligation to answer; generally physicians will be glad to discuss these questions with you.

Weighing the relative importance of information is as essential as acquiring it. Deciding the significance of large support staffs, group practice, post-graduage education, etc. is up to you, perhaps in consultation with others whose opinions you respect. Physicians themselves, however, are likely to disagree on these matters. Personal preferences also differ and you must take yours into account. One source of information is other patients; consulting them you may learn something about a physician's personality or the length of time it is usually necessary to spend in the waiting room after your appointed time. Remember though that this source of information must also be weighed ac-

cording to that person's preferences which may differ from yours, and against the experiences of others.

If you should question the accuracy of any of this date on some basis other than currency take it up first with the physician concerned and, if it is not settled there, with the Whatcom County Medical Society and/or Fairhaven College.

Several physicians added qualifying or explanatory comments to some of the answers, but for the sake of comparability these have been left out of the Directory. In all cases, the individual physician is the final authority on information concerning his or her practice.

HOW TO USE THIS DIRECTORY

The physician listings you will find in these pages are the product of a questionnaire which was sent to every practicing physician in Whatcom County. Listings have been placed in alphabetical order and the information provided has been standardized so that a reasonable comparison between physician practicing in the same specialty area may be made.

Please note that each specialty or specialties which are listed use the approved AMA specialty designations. If a physician lists more than one specialty, then he is either Board Certified or Board eligible in all specialty areas listed.

The following codes have been established to designate questions which do not necessarily fit the practice pattern of the physician being questioned:

1. NR—No Response
2. NA—Not applicable to that physicians practice.
3. DNRQ—Did not return questionnaire.

If you are not clear as to the type of medical practice performed by a particular specialty, you should feel free to discuss this matter with the physician or the physician's staff whose services you are seeking.

J. DONALD ANDERSON, M.D.

INTRODUCTORY INFORMATION:

1130 N. Forest
Bellingham
733-6300
Ophthalmology
Restricts practice to specialty; group practice (3), Ophthalmology.
Support personnel: 1 RN, 2 medical assistants, 2 secretary/bookkeepers, 1 receptionist.

EDUCATION, CERTIFICATION, APPOINTMENTS:

University of Mississippi, 1965.
Internship: University Medical Center, Jackson, Mississippi, 1965-66.
Residency: Ophthalmology Residency, Ohio State University, 1970-73.
Board Certified:
American Board of Ophthalmology.

AVAILABILITY:

Usually see patients by appointment only.
Office hours: 9-5:30 Mon., Tues., Thurs., Fri.; 9-12:30 Wed. and same Saturday. Office open every Sat.
Is usually available to patients for phone consultation during office hours, no fee; has telephone answering service.
After hours coverage:
Evenings: Ans. serv., or can be reached at home.
Weekends: Ans. serv., or can be reached at home.
Vacations: Other doctor covering
Does not make housecalls.
Will accept new patients.
Usual advance notice for routine office visit: 1-2 days.

FEES AND BILLING INFORMATION:

Minimum fee for initial office visit $12.00; for follow-up office visit $8.00. Minimum fee for initial hospital visit: $15.00; for follow-up hospital visit: $10.00.
Proof of ability to pay not required at time of appointment.
Office bills monthly; bills are itemized.
Inquiries or complaints about billing are referred to secretary/bookkeeper.
Medicaid or Public Assistance patients are accepted.
Medicare fees are accepted as payment in full.

PRACTICE INFORMATION:

Drugs are usually prescribed by generic name.
Provides information on preventive medicine.
Will make records available to other physician.

WAYNE W. AUSTIN, M.D.

INTRODUCTORY INFORMATION:

Bellingham Medical Center
Bellingham
734-1212
General Practice
Restricts practice to specialty; solo practice.
Support personnel: 2 RNs, 1 secretary/bookkeeper.

EDUCATION, CERTIFICATION, APPOINTMENTS:

Loma Linda University, 1953.
Internship: Portland Adventist Hospital, Portland, Oregon, 1953-54.
Residency: NA

AVAILABILITY:

Usually sees patients by appointment only.
Office hours: 9:30-5 Mon., Tues., 9:00-5 Wed., 9:30-5 Thurs., 9:00-12 Fri.

Is available to patients for phone consultation during office hours; has answering service, no fee.
After hours coverage:
Evenings: Ans. service, at home.
Weekends: Ans. service, at home, other doctor covering.
Vacations: Other doctor covering.
Will make housecalls, fee: day—$20
night—$25
Does not accept new patients (only new maternity).
Usual advance notice for routine office visit:
1½ to 2 weeks.
Can speak some Spanish.

FEES AND BILLING INFORMATION:
Minimum fee for initial office visit $13.00; for follow-up office visit $13.00. Minimum fee for initial hospital visit: $25.00; for follow-up hospital visit: $9.00.
Proof of ability to pay not required at time of appointment.
Office bills monthly; bills are itemized.
Inquiries or complaints about billings are discussed with patients then referred to bookkeeper.
Medicaid or Public Assistance patients will be accepted (new maternity).
Accepts Medicare fees as payment in full.

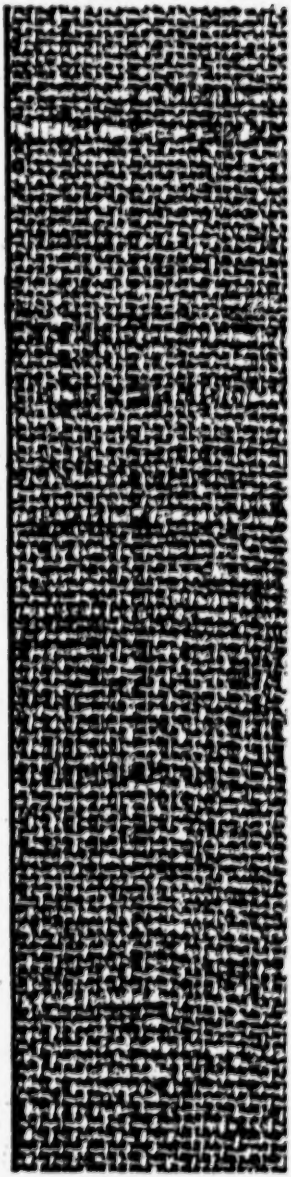
PRACTICE INFORMATION:
Prescribes contraception.
Does not usually prescribe drugs by generic name, but will do so on request.
Provides information on preventive medicine.
Will make records available to other physicians.

RX 666—Excerpts From "Consumer Directory of Pittsburgh Primary Care Physicians" (1976)

PRICE: $2.00

RX 666

Consumer Directory of Pittsburgh Primary Care Physicians



INCLUDES: WHAT TO LOOK FOR IN A MEDICAL CHECKUP; DOCTOR-PATIENT COMMUNICATIONS; LISTING OF PITTSBURGH PHYSICIANS; FEE INFORMATION; A FAMILY GUIDE TO IMMUNIZATIONS

Dear Reader:

On behalf of the Allegheny County Medical Society and the Pittsburgh Free Clinic, we would like to express our appreciation to the physicians who cooperated in providing the information included in this directory. This directory is the product of a joint venture between the Medical Society and the Patients' Rights Program of the Free Clinic in an effort to obtain meaningful data regarding the availability of physicians in primary care within the City of Pittsburgh. This directory lists all physicians who have responded to our requests for information to be published in this directory.

It should be stressed that the directory includes only physicians in primary care practices. This would include general practitioners, family practitioners, pediatricians, internists, and gynecologists. We wish to emphasize that we are in no way attempting to evaluate the quality of care provided by these physicians. The purpose of the directory is to provide the consumer and related health and social service agencies with information relating to accessibility of an individual practitioner, information which is not typically available to the consumer. In order to make an informed choice when selecting a physician, consumers need to have certain basic information such as office hours, procedures, fees, and hospital affiliations.

The Pittsburgh Free Clinic is a non-profit corporation servicing approximately 15,000 patient visits per year, seeing many patients from various income and geographic locations, but focusing its efforts on providing primary health care to young adults. The Patient's Rights Program, a special program of the Free Clinic, supports community education for health consumers.

The Allegheny County Medical Society is a non-profit professional association with a membership of approximately 2,300 physicians dedicated to providing the best possible health care in the community and advancing the ideals of the medical profession.

These two organizations have joined together to publish this directory.

Most of the information in this directory is correct; however, the consumer should check with the physician's office since certain information may have changed between the time the information was received (Fall '75) and published (Fall '76).

We sincerely hope that this directory will be of practical value to the health-care consumers in Allegheny county.

Sincerely,

Lawrence D. Ellis, M.D.
Chairman, P.R. Committee, ACMS

David M. McConnell, Jr., M.D.
President, Pittsburgh Free Clinic

TABLE OF CONTENTS

Introduction P.1
How To Use This Directory P.3
I. Introductory Information P.3
II. Availability P.4
III. Fees and Billing P.5
IV. Practice Information P.6
What To Look For In A Medical Checkup P.8
Listing Of Individual Physicians P.11

—Family Practitioners ..... Family Practitioners
—General Practitioners ..... General Practitioners
—Gynecologists ..... Gynecologists
—Internists ..... Internists
—Pediatricians ..... Pediatricians

Appendices
Appendix A: A Family Guide To Immunizations i
Appendix B: Copy Of Letter & Questionnaire Mailed To Physicians .. ii
Appendix C: Physicians' Fees-Averages & Fee Range v

Index: Alphabetical Listing of Physicians by Zip Code

Publication of this Directory was made possible by support from the following groups:

Allegheny Children & Youth Service Council
Allegheny County Medical Society Foundation
Blue Cross of Western Pennsylvania
Health Screening and Research Foundation
Howard Heinz Endowment
Maurice Falk Medical Fund
Pennsylvania State Health Department
Program to Aid Citizen Enterprise (P.A.C.E.)
South Oakland Citizens' Council

These organizations, however, are not the authors or proprietors presented here and are not endorsing any statement or information expressed herein.

INTRODUCTION

In today's confusing world, more and more people are stopping to consider the question: how should we choose our doctors? Should we ask for a recommendation from friends? Relatives? Clergy? Our former physician in another part of town? The Yellow Pages?

Informed decisions require adequate information. In the last few years, consumer groups have developed "consumer directories" of physicians. Such directories have appeared in more than 25 states across the country. Typically, they include information ranging from the doctor's services and fees to average waiting time to get an appointment.

This Pittsburgh Physicians' Directory is different from others in that it is one of the few which has been jointly produced by a local medical society and a consumer organization.

THE PURPOSE OF THIS DIRECTORY

What information will the Pittsburgh Directory tell you about selecting a doctor?

This directory contains material which has been previously unavailable in any published form. Information relating to the accessibility of an individual physician (office hours, waiting time for an appointment, hospital affiliations, etc.) is basic and important to think about before selecting a physician.

Most people will naturally want to know: "Will the Directory be able to tell me how 'good' a doctor is?" Unfortunately, the answer is NO. While consumers do have a right and responsibility to evaluate their doctors, information about the quality of care cannot be offered here. Hopefully, the Directory will encourage you to ask your doctor questions about your care.

PHYSICIANS INCLUDED IN THIS DIRECTORY

Does the Directory list all physicians in the Pittsburgh area? Again, the answer is NO.

First, the Directory is designed to provide information about those doctors active in primary care. A primary care physician is one who offers basic and

continuing care for the range of health problems which routinely occur in individuals and families. This care would be generally available on a day-to-day basis, and would include routine and preventative care, minor problems, and most acute illnesses. Primary care physicians include:

General Practitioners (G.P.'s)—general family medicine
Family Practitioners—general family medicine
Pediatricians—medical care for children
Internists—adult medicine
Gynecologists—specialized care for women

SPECIALISTS ARE NOT INCLUDED (for example, allergists, dermatologists, ophthalmologists, surgeons). Providing information about specialists would be a more complex task, requiring separate questions for each specialty. In addition, a patient must frequently be referred to a specialist by a primary care physician.

Second, the Directory lists only those primary care physicians active in patient care primarily within the City of Pittsburgh. We listed those doctors who practice in the 152 zipcode areas. All the doctors in the county were not surveyed simply because of the numbers of physicians involved. Hopefully, in the future, there will be a Physicians' Directory for all of Allegheny County.

Third, the Directory is designed to provide information only about doctors active in patient care. Thus, if a physician teaches medicine and does not see patients, or if a doctor is retired, he/she would not be included.

Finally, the Directory includes only those physicians who responded to the questionnaire mailed to them for information. Our closest estimates indicate that the Directory includes about 60% of the primary care physicians appropriate for the survey.

METHODOLOGY: HOW WAS THE INFORMATION COMPILED?

The project began in 1974 when the Allegheny County Medical Society and the Pittsburgh Free Clinic's Patients' Rights Program began discussions. A questionnaire was agreed upon and, during the Fall of 1975, approximately 800 questionnaires were mailed to primary care physicians in Allegheny County. (IT IS IMPORTANT TO KEEP IN MIND THAT THE DIRECTORY'S INFORMATION IS AT LEAST ONE YEAR OLD.)

The mailing list of doctors was compiled using the membership list of the Allegheny County Medical Society and a national directory for Allegheny County compiled by the American Medical Association. This latter list included non-medical society members. We hoped in this way to reach all Allegheny County primary care physicians. Unfortunately, we probably missed a number of doctors who should have been included in the guide, and we wish to apologize in advance to those physicians for this unintentional omission.

Physicians were asked to return the questionnaire by mail. More than 400 of the 800 questionnaires were sent back. Approximately 230 of these could be included in the Directory. Staff volunteers spent several months compiling the results. Follow-up calls were made to doctors when clarification was necessary. The data was then organized into a standardized format.

We wish to emphasize that the questionnaires were filled out by responding doctors in the Fall of 1975. You should contact the physician's office to make sure the information is currently correct.

HOW TO USE THIS DIRECTORY

The collected information about the responding primary care physicians is listed alphabetically by last name under the individual physician's specialty. For each doctor, the available information is divided into four sections: Introductory Information, Availability, Fees and Billing, and Practice Information.

I. INTRODUCTORY INFORMATION

This section lists basic information about a physician's practice: Where is it? What kind is it? In which hospitals does the physician primarily practice?

PHYSICIAN TRAINING

General practitioners have completed, at least, medical school and an internship. (Internship is a training period, usually one year, taken after medical school.) Family practitioners, internists, pediatricians, and gynecologists have taken a residency and/or other special training in addition to medical school and an internship. (Residency is a training period, from one to several years, taken after an internship.)

PHYSICIAN CERTIFICATION

A board-certified physician is one who has passed an examination given by a medical specialty board. Certification indicates that a physician is qualified in that area of medicine, and usually the practice is limited to that specialty. A board-eligible physician has finished specialty training but has not completed all stages of the certifying examination.

The fact that a doctor is board-certified or board-eligible does not necessarily guarantee the highest quality care, but these credentials are evidence that a doctor has been properly trained in his/her medical field. Some internists and pediatricians have subspecialties and some restrict their practices to that subspecialty. (They would not, therefore, be considered primary care physicians and would not appear in this Directory.)

ORGANIZATION OF PRACTICE

Physicians can practice alone (solo) or in a group. Either arrangement has its advantages. If you select a solo practitioner, you know you will be seen by that doctor only. Some people prefer that one-to-one relationship. But if you choose a doctor in group practice, you may be assured of treatment by another physician if your doctor is unavailable, as well as access by the partner to your records.

There are two types of group practice. In one, doctors in different specialties pool their talents; for example, an internist, an obstetrician, a pediatrician, and a surgeon. That arrangement may provide patients with both a variety of expertise and integrated medical care. In the second type, several doctors engaged in the practice of a single specialty (for example, family medicine or pediatrics) work together under one roof and share facilities. These doctors can readily consult each other regarding diagnosis and treatment, and rotate their after hours coverage.

PHYSICIAN AGE AND YEARS IN PRACTICE

A physician's age or the number of years in practice are not indicators of professional quality. They are listed here simply for your information.

HOSPITALS

We have listed the hospital(s) with which the doctor is associated. If hospitalization is needed, you would probably be sent to one of these hospitals. It is important that patients realize that choosing a doctor also means choosing a hospital.

II. AVAILABILITY

Whether a doctor is accepting new patients is a prime consideration. But even if the answer reads "no" in this Directory, it is possible that the situation has changed since the survey was done. Phone the doctor's office to find out if patients are now being accepted.

APPOINTMENTS

It is helpful to know if a doctor will see you without an appointment. Although you may enjoy having that privilege, most doctors limit "walk-ins" or "call-ins" to emergency cases because of the scheduling difficulties it causes. Note the doctor's office hours. Do they fit in with your schedule?

AFTER-HOURS COVERAGE

Since you cannot time your illnesses to a doctor's office schedule, consider the provisions for after-hours coverage. When your own doctor is out of town, another doctor should be available in case an emergency arises. Many physicians utilize professional telephone answering services (abbreviated in guide itself as "TAS").

HOUSE CALLS

House calls are no longer standard medical procedure. In most cases, you are better off being treated in the doctor's office or a hospital emergency room, where diagnostic aids and other medical equipment are available.

Some doctors do make house calls to incapacitated patients who cannot be easily transported.

LIMITATIONS

Note if the doctor sets an age limit for new patients, and what the limit is. These limitations especially apply when parents are seeking care for their children. Some physicians also have geographic limits to their practice.

III. FEES AND BILLING

How much will you have to pay for physician's services? Despite reluctance by patients to ask about a doctor's fees, it is an important question—one that we encourage you to ask before the services are rendered.

The physicians responding to this survey chose several options in answering the "fees and billing" questions. Some listed all their fees for publication; others requested that their fees by used only to establish a range and average in their particular field of practice. (These figures are listed in Appendix C.) Some physicians did not answer the fee questions at all, but did indicate they would discuss fees with patients over the phone or in person.

The fees listed will give you some idea of comparative fee structures among doctors, but don't be surprised if fees are somewhat different by the time you select and visit a doctor. The fees charged by a doctor in no way reflect his/her professional competence and should not be used to determine the quality of care. The scope of the examination on an initial office visit also varies from doctor to doctor and will result in different rates.

Doctors' billing practices also vary. It is inappropriate for a physician to require that full payment be made before services are rendered. However, cash payments requested at the end of a visit are not uncommon. Itemization of services (although not always done) will help you understand your bill better, since you can see the individual charge for each service. Also, itemization of bills is required by many insurers.

If you have private health insurance (for example, Blue Cross/Blue Shield) you should check to see whether or not your policy covers physician office visits. If it does, next check to see if your physician accepts the insurance company's fee schedule as payment in full.

MEDICAL ASSISTANCE AND MEDICARE

Whether a doctor accepts "Medicaid" or Medical Assistance patients (Medicaid is a State-administered medical insurance program for low-income patients) is vital information to those people who qualify for the program. Please note that in the State of Pennsylvania it is illegal for the doctor to charge Medical Assistance patients a fee in addition to the Medical Assistance payments the physician receives. In the guide, "MEDICAL ASSISTANCE" is abbreviated as "DPA/MA." If you have questions about Pennsylvania's Medical Assistance Program, you should contact the Allegheny County Board of Assistance Penn Avenue office (565-5611).

Most doctors accept Medicare patients (Medicare is the federal insurance program for the elderly); but not all accept the Medicare fee schedule as

payment in full, and may bill the patient an additional fee. If the bill is higher than the amount Medicare will cover, the patient must pay the difference. If you have questions about the Medicare program, you should contact the Social Security Administration.

IV. PRACTICE INFORMATION

It is probably more convenient and less costly for the patient if a doctor's office is equipped for common diagnostic procedures. If lab tests are not performed in the office, you may receive a separate bill for the lab work. In either case, the lab fees are in addition to the basic office visit fee.

CONTRACEPTION

Any woman using or planning to use a particular form of contraception should know before she makes the first appointment whether the doctor is willing to prescribe that method. This consideration applies in choosing either a personal physician or a gynecologist. Some physicians, for religious or other reasons, refuse to prescribe or recommend certain types of contraception.

WHAT TO LOOK FOR IN A MEDICAL CHECK-UP

What should you expect to happen when you see a physician for a medical check-up? The exact details will be different for patients of different ages and having different problems. But certain basic questions will be considered by your physician whenever you are seen: Are you healthy? If so, what should be done to help you stay that way? If not, what should be done to find out more about your problem and help relieve it?

If you are between the ages of 20 and 40, your physician may advise a check-up every two or three years. After age 40, he/she may advise a check-up once a year. Certainly, if you are having serious health problems, you will need to be seen more often. Also, young children are routinely seen more frequently.

Not every medical exam will be a "complete exam," particularly if you are being seen several times for a specific problem. However, the initial evaluation and other "routine" exams will generally cover a broad range of areas. The major parts of the check-up are the history, the physical examination, the laboratory tests, and the treatment.

Remember to ask questions if you do not understand what your physician is saying to you.

HISTORY

The first part of your check-up is a medical history, which consists of questions about present and past medical problems, as well as immunizations, medications, history of illness in family members, and social factors

(occupation, travel, habits such as drinking or smoking). A "review of systems" also asks about many common symptoms you may or may not have. Women will be asked about their menstrual cycle and pregnancy history.

The exact questions that are asked will vary, depending on the doctor and the circumstances. More detailed questions would, of course, be asked about particular problems you may have.

PHYSICAL EXAMINATION

As mentioned above, the extent of the exam and the areas to be examined will vary—depending on the type of problem, the patient's age, the individual doctor, and many other factors. Certain problems are more common at certain ages, so that different aspects of the exam would be emphasized for a child than for an adult, for example.

Details on how the areas of the body are examined can be found in most books on health. But remember that a "complete exam" varies from doctor to doctor, as well as patient to patient.

LABORATORY TESTS

Just as with the history and physical exam, there are certain tests that will be done routinely and others that will be ordered if a specific problem is suspected. Again, different tests will be done by different doctors depending on the situation. For example, only a limited number of screening tests are done on infants and children, but usually more are done on adults, especially over age 40. Other preventative care may also be given, such as immunizations.(See "Family Guide to Immunizations," Appendix A.)

Some of the common tests are listed under the individual doctor's names, including hemoglobin (or hematocrit), electrocardiogram, urinalysis, throat culture, pap smear, pregnancy test, and venereal disease tests. (See note at the bottom of this page.) Many tests for specific problems would, of course,

---

Note: Below is an explanation of common laboratory tests listed under each physician's name.

Complete Blood Count (CBC)—A blood test to check the number and percentage of red cells and white cells, concentration of hemaglobin (low in anemia).

Hemaglobin & Hematocrit (H&H or Hgb&Hct)—A blood test to check the red cells, as to concentration of Hgb and percentage of cells in the body. Part of the CBC.

Urinalysis (UA)—Examination of urine for abnormalities or conditions such as diabetes, kidney or bladder infection, or poorly functioning kidneys, protein in the urine, etc.

Throat Culture (T.C.)—A throat swab, taken to check for bacterial infection such as **Streptococcus** ("strep throat").

Pap smear—A sample of cells and mucus taken from the cervix (tip of the womb) to check for cancer and other abnormalities; usually done with the woman's pelvic exam.

Venereal Disease Tests—Tests for diseases which are usually transmitted by sexual intercourse. The most common are gonorrhea (tested by microscope exam of secretions or by "G. C" culture) and syphilis (checked with a blood test, called a "serology").

Electrocardiogram (ECG, EKG)—A heart tracing, in which the heart's electrical activity is recorded on a strip of paper to check for problems. (Often done with a chest X-Ray, which would show the size of the heart shadow.).

have to be done outside the doctor's office.

In the listings, you will see a chart with the fee for some of the tests and whether it is done in the office. Usually a separate bill will be sent to you for labwork done outside the office; that done in the office will have the fee added to the basic office visit charge. Check your insurance coverage for laboratory work, since some programs cover certain tests, either partly or completely.

TREATMENT

Once your physician has reached a decision about the problem you have and discussed it with you, he/she will recommend some treatment for it. A few problems can be taken care of right away in the office, but usually you will need to continue your care at home. To make sure you remember the plan of care, you should have something in writing: either write it down yourself or ask your doctor to write it down. This should include the name of the problem, any equipment or medication needed (including any serious side effects), any limitation in activity or diet, complications to watch for, and the date and time of your follow-up appointment.

You will probably want to ask about your prognosis (the probable course and outcome of your illness) and about ways to prevent the problem from recurring. If you need some procedure or surgery done, you may want to know more details about how the procedure will affect you—such as how long you will be hospitalized, the expected length of recuperation at home, the approximate cost, and so on.

Much of the success of a treatment plan depends on how well you understand what has to be done and why it is important. And the key to this understanding is good doctor-patient communication.

DOCTOR-PATIENT COMMUNICATIONS

This Directory is a first step in providing consumers with basic information they need to choose a physician, based on their needs and preferences. Simply having the information available, however, does not guarantee the consumer that she/he will be perfectly satisfied with care received from a particular physician listed in the Directory.

It is difficult to establish set standards of good medical practice to help the consumer evaluate quality of care. What constitutes proper care varies from situation to situation depending on the individual's medical condition and other related factors. Individuals also judge good medical care by different standards. What pleases one person about the way a physician treats his/her patients may not please someone else.

This is not to say that consumers cannot evaluate medical care they receive or make decisions about their care. The consumer movement in this country has increased society's level of understanding and knowledge about all kinds of consumer services. It has also encouraged consumers to assume greater responsibility for ensuring that the services they pay for and receive are adequate.

Increasingly, the area of health care is being viewed in these terms. The consumer of health services (patient) as well as the provider (physician, or other health professional) is expected to assume greater responsibility in promoting quality health care services. Open, honest communication is key to establishing a patient-physician relationship that emphasizes this shared responsibility. Below are suggestions that may possibly aid in better communication between patients and their physicians.

YOUR RESPONSIBILITIES AS A PATIENT

1. Take an active interest in your health care. Ask the doctor questions about all aspects of your care. In the long-run, your health is your own responsibility.

2. Be frank and provide the doctor full information about any facts related to your illness. Co-operate in giving the doctor all the necessary information he/she must have in making an adequate diagnosis or treatment plan for you.

3. Make sure that you have all the information that is necessary and relevant to making decisions about your possible treatment so you can give your INFORMED CONSENT prior to treatment. Consider the issues discussed in the "MEDICAL CHECK-UP" section under "Treatment."

4. Make sure you follow all instructions your doctor gives you related to your treatment plan. If you do not understand or cannot follow instructions relating to the treatment and prevention of a recurrence of your illness, tell your physician.

5. Remember that your doctor is human—that he/she has the same emotions as anyone else. Don't view your doctor as a "Marcus Welby." Doctors cannot cure all your problems and doctors are not immune from making errors.

6. If you have a complaint about any aspect of your care, first discuss it with your physician. Oftentimes, communicating the problem to your doctor is the best means of resolving it. Your doctor should know about your concern in order to prevent it from occurring again. If the doctor is unwilling to discuss the problem or resolve it to your satisfaction, you may wish to contact The Allegheny County Medical Society (321-5030).

FOR EVERY PATIENT RESPONSIBILITY LISTED ABOVE, THE PHYSICIAN HAS A RELATED RESPONSIBILITY. THUS, RECEIVING GOOD MEDICAL CARE DEPENDS ON BOTH THE PATIENT AND THE DOCTOR.

Carl E. Anderson, M.D.
3700 Fifth Ave., Pgh.,Pa. 15213
681-1665
Family Practice
Age:55
Yrs. In Practice: 21
Type of Practice: Solo

Availability

New Patients by Referral Only
By Appointment Only
Age Limits: 16 yrs. & over
After Hours Coverage: TAS
Covered By: Other Physician
Presbyterian-University, Eye & Ear(consulting)
Office Hours: Mon.-Fri. 10:20-12 p.m.
1-5 p.m.

Fees and Billing

Will Discuss Fees in Office or by Phone
Accepts Medicare
DPA/MA at Doctor's Discretion
Payment via routine billing
Will itemize bill
Does not prescribe contraceptives

Average waiting time for appointment:
4-6 weeks

Office equipped to carry out the following:

	OFFICE	REFERRED		OFFICE	REFERRED
Hgb or Hct	x		Pelvic Exam		
ECG	x		Serology		x
Urinalysis	x		Preg.Test		
Throat Culture		x	G.C.Testing		
Pap Smear					

Edward L. Bamonte, M.D.
5400 Centre Ave., Pgh.,Pa. 15232
681-4500
Family Practice
Age: 46
Yrs. in Practice: 20
Type of Practice: Solo

Availability

Accepts New Patients
By Appointment Only
Occasional Housecalls
Age Limits: 12 yrs. & over
No Geographic Limits
After Hours Coverage: TAS
Covered By: Other Physician
Shadyside
Office Hours: Monday, Tuesday, Thursday,
Friday, Saturday mornings

Fees and Billing

Will Discuss Fees in Office
Accepts Medicare & Assignment Fee
DPA/MA Accepted Routinely
Payment via routine billing
Will itemize bill
Average Charges: Office Visit: $15-25
Return Visit: $10-12
House Calls: $15
Prescribes Contraceptives by Refills only

Average waiting time for appointment:
1-2 weeks

Office equipped to carry out the following:

	OFFICE	REFERRED		OFFICE	REFERRED
Hgb or Hct	X		Pelvic Exam		X
ECG	X		Serology	X	
Urinalysis	X		Preg.Test		X
Throat Culture			G.C.Testing		X
Pap Smear		X			

Samuel F. Barone, M.D.
813 Warrington Ave., Pgh., Pa. 15210
381-3475
Family Practice
Age: 55
Yrs. in Practice: 28
Type of Practice: Solo

Availability

Accepts New Patients
By Appointment Only
Housecalls: Old Patients Only
No Age Limit
After Hours Coverage: TAS
Covered By: Other Physician; Hospital Emergency Room
South Side
Office Hours: Monday, Tuesday, Thursday, Friday 1-5 p.m.; Saturdays 10 a.m.-1 p.m.

Fees and Billing

Will Discuss Fees
Accepts Medicare; No Assignment Fee
DPA/MA only South Side/Mt.Washington/S.Hills
Payment at time of Visit
Will itemize bill
Average Charges: Office Visit: $10
Return Visit: $10
House Calls: $15
Child Immunization-Polio: $3
Does not Prescribe Contraceptives

Average waiting time for appointment:
1-2 days

Office equipped to carry out the following:

	OFFICE	REFERRED		OFFICE	REFERRED
Hgb or Hct		X	Pelvic Exam		
ECG		X	Serology		X
Urinalysis	X		Preg.Test		X
Throat Culture			G.C.Testing		X
Pap Smear					

George H. Benz, Sr.
736 Brownsville Rd., Pgh.,Pa. 15210
381-4933
Family Practice-Internal Medicine
Age: 63
Yrs. in Practice: 34
Type of Practice: Solo

Availability

Accepts New Patients
No Appointment Needed
Occasional Housecalls
No Age Limit
No Geographic Limits
After Hours Coverage: TAS
Covered By: Other Physician; Hospital Emergency Room
St. Joseph's
Office Hours: Mon.-Fri. 2-5 p.m.

Fees and Billing

Will Discuss Fees in Office
Accepts Medicare
DPA/MA at Doctor's Discretion
Payment at time of visit or via billing
Does not Prescribe Contraceptives

Average waiting time for appointment:
24 - 48 hours

Office equipped to carry out the following:

	OFFICE	REFERRED		OFFICE	REFERRED
Hgb or Hct		X	Pelvic Exam	X	
ECG	X		Serology		X
Urinalysis	X		Preg.Test		X
Throat Culture		X	G.C.Testing		X
Pap Smear	X				

James J. Brungo, M.D.
2341 Perrysville Ave., Pgh., Pa. 15214
231-6400
Family Practice - 50%
Occupational - 50%
Age: 54
Yrs. in Practice: 30
Type of Practice: Solo

Availability

No New Patients-Limited Private Prac.
By Appointment Only
Housecalls: yes
Age Limits: School age & above
No Geographic Limits
After Hours Coverage: TAS
Covered By: Other Physician; Hospital Emergency Room
Divine Providence
Office Hours: Monday, Tuesday, Thursday, Friday 1:30-5:30 p.m.
Saturday 8:30-1 p.m.

Fees and Billing

Will Discuss Fees in Office or by Phone
Accepts Medicare & Assignment Fee
DPA/MA Accepted Routinely
Payment at time of visit or via billing
Will itemize bill

Average waiting time for appointment:
N.A.

Office equipped to carry out the following:

	OFFICE	REFERRED		OFFICE	REFERRED
Hgb or Hct		X	Pelvic Exam		X
ECG		X	Serology		X
Urinalysis	X		Preg.Test		X
Throat Culture		X	G.C.Testing		X
Pap Smear		X			

Leonard A. Burgard, M.D.
7430 Washington St., Pgh., Pa. 15218
271-5566
General Practice
Age: 66
Yrs. in Practice: 37
Type of Practice: Solo

Availability

No New Patients
No Appointment Needed
Housecalls: No
No Age Limit
Geographic Limits: Swissvale/Edgewood
After Hours Coverage: Home Phone
Covered By: Other Physician
Office Hours: Mon.-Fri. 11 a.m-2 p.m
6 p.m. - 7 p.m.
Tues. 11 a.m. - 2 p.m.
Sat. 9 a.m - 11 a.m.

Fees and Billing

Accepts Regular Medicare Patients
DPA/MA Rarely Accepted
Payment via routine billing
Will itemize bill
Does not Prescribe Contraceptives

Average waiting time for appointment:

Office equipped to carry out the following:

	OFFICE	REFERRED		OFFICE	REFERRED
Hgb or Hct			Pelvic Exam		
ECG			Serology		
Urinalysis			Preg.Test		
Throat Culture			G.C.Testing		
Pap Smear					

PHYSICIANS FEES

Appendix C

Averages & Fee Range

PEDIATRICIANS

OVERALL NUMBER OF DOCTORS PARTICIPATING: 28

	LOW AMOUNT	HIGH AMOUNT	AVERAGE	No. of Responses
Initial Office Visit:	$8.00	$50.00	$15.75	28
Phone Consultation:	0.00	1.00	0.00	28
Routine Return Visit:	8.00	13.00	10.00	28
House Calls:	12.00	20.00	15.00	12
POLIO Immunization:	1.00	5.00	3.00	21
DPT Immunization:	2.00	4.00	3.25	21
MMR Immunization:	5.00	24.00	12.00	13
Hgb or Hct:	2.00	10.00	3.75	26
ECG:	20.00	20.00	20.00	2
Urinalysis:	1.00	5.00	3.00	26
Throat Culture:	3.00	10.00	4.50	20
Pap Smear:	10.00	10.00	10.00	1
Pelvic Exam:	15.00	15.00	15.00	1
Serology:	--	--	--	0
Preg. Test:	7.50	7.50	7.50	1
G. C. Testing:	5.00	10.00	8.25	3

FAMILY PRACTITIONERS

OVERALL NUMBER OF DOCTORS PARTICIPATING: 30

	LOW AMOUNT	HIGH AMOUNT	AVERAGE	No. of Responses
Initial Office Visit:	$7.00	$16.00	$10.75	30
Phone Consultation:	0.00	5.00	0.00	30
Routine Return Visit:	7.00	12.00	9.50	30
House Calls:	12.00	20.00	16.00	28
POLIO Immunization:	2.00	10.00	4.00	20
DPT Immunization:	1.00	10.00	4.00	19
MMR Immunization:	2.00	27.00	9.25	18
Hgb or Hct:	1.00	8.00	3.00	17
ECG:	10.00	25.00	18.00	21
Urinalysis:	1.00	5.00	2.50	20
Throat Culture:	2.00	15.00	7.00	10
Pap Smear:	3.00	20.00	7.00	20
Pelvic Exam:	3.00	20.00	10.25	17
Serology:	1.00	14.00	6.00	15
Preg. Test:	2.00	10.00	6.00	9
G. C. Testing:	2.00	10.00	5.50	6

GENERAL PRACTITIONERS

OVERALL NUMBER OF DOCTORS PARTICIPATING: 44

	LOW AMOUNT	HIGH AMOUNT	AVERAGE	No. of responses
Initial Office Visit:	$5.00	$25.00	$9.00	44
Phone Consultation:	0.00	5.00	1.00	44
Routine Return Visit:	5.00	25.00	8.75	44
House Calls:	6.00	25.00	15.00	38
POLIO Immunization:	1.00	12.00	5.25	17
DPT Immunization:	1.00	12.00	5.00	17
MMR Immunization:	3.00	15.00	8.00	14
Hgb or Hct:	2.00	6.00	3.00	15

GENERAL PRACTITIONERS, Continued

	LOW AMOUNT	HIGH AMOUNT	AVERAGE	No. of Responses
ECG:	$10.00	$20.00	$17.00	12
Urinalysis:	1.00	5.00	2.50	18
Throat Culture:	2.00	5.00	3.25	7
Pap Smear:	2.00	17.00	10.00	18
Pelvic Exam:	2.00	20.00	10.00	20
Serology:	2.00	14.00	6.00	11
Preg. Test:	4.00	10.00	6.50	5
G. C. Testing:	2.00	6.00	4.50	6

OBSTETRICIANS & GYNECOLOGISTS

OVERALL NUMBER OF DOCTORS PARTICIPATING: 42

	LOW AMOUNT	HIGH AMOUNT	AVERAGE	No. of Responses
Initial Office Visit:	$15.00	$35.00	$23.00	42
Phone Consultation:	0.00	0.00	0.00	42
Routine Return Visit:	8.00	25.00	4.25	41
House Calls:	20.00	20.00	20.00	2
POLIO Immunization:	–	–	–	0
DPT Immunization:	–	–	–	0
MMR Immunization:	–	–	–	0
Hgb or Hct:	1.00	15.00	4.25	8
ECG:	–	–	–	0
Urinalysis:	1.00	10.00	3.25	7
Throat Culture:	10.00	10.00	10.00	1
Pap Smear:	5.00	20.00	6.50	13
Pelvic Exam:	7.00	15.00	12.00	13
Serology:	5.00	20.00	9.50	4
Preg. Test:	5.00	20.00	6.00	13
G. C. Testing:	5.00	20.00	9.75	8

INTERNISTS

OVERALL NUMBER OF DOCTORS PARTICIPATING: 40

	LOW AMOUNT	HIGH AMOUNT	AVERAGE	No. of Responses
Initial Office Visit:	$10.00	$80.00	$29.50	40
Phone Consultation:	0.00	2.00	0.00	40
Routine Return Visit:	7.00	15.00	12.00	40
House Calls:	10.00	25.00	16.00	21
POLIO Immunization:	1.00	2.00	2.00	3
DPT Immunization:	1.00	3.00	2.50	3
MMR Immunization:	1.00	8.00	6.00	3
Hgb or Hct:	2.00	5.00	3.25	21
ECG:	15.00	25.00	19.25	26
Urinalysis:	2.00	5.50	3.25	22
Throat Culture:	3.00	20.00	6.00	7
Pap Smear:	6.00	15.00	9.40	10
Pelvic Exam:	5.00	15.00	10.30	13
Serology:	0.00	5.00	3.50	6
Preg. Test:	3.00	10.00	6.75	4
G. C. Testing:	0.00	5.00	3.25	3

[4308] **Excerpts of Transcript of Testimony of Bruce Nortell, Esq.**

Tr. 4308-4312, 4333-4354, 4360-4361

By Mr. Bierig:

Q. In this letter are you suggesting that this particular problem is a matter to be resolved between the physician and the telephone company? As a general matter is it the policy of the AMA that disputes of this nature should be resolved between the physician and the telephone company?

A. I would say generally speaking, yes. The telephone company has the ultimate responsibility and authority for what they print in a telephone directory. And any individual physician has the ultimate responsibility and authority to determine whether or not he wants his or her name listed in the telephone directory.

[4309] Q. Was this the position of the American Medical Association as of December 1, 1976 when this letter was written?

A. Yes.

Q. Were you aware, Mr. Nortell, at the time you wrote this letter that the Federal Trade Commission was concerned about the issue of medical society involvement with listings of physician's names in the telephone directory?

A. Let's see, this letter is dated December of '76. I believe the FTC litigation was filed the previous year.

Q. Are you aware of the litigation—but you were aware of the specific matters that could come up in the litigation?

A. Not that I recall. I was generally aware of the fact that the complaint, of course, had indicated the question of advertising and solicitation was at issue in the matter but nothing as specific as this, no.

Q. I show now a copy of what has been marked as Respondent Exhibit 550 A through D and ask you if you can identify this document?

(The document referred to was marked Respondent Exhibit RX 550 for identification.)

MR. BIERIG: Your Honor, we withheld ruling on this other, perhaps we should clarify this one.

[4310] JUDGE BARNES: Answer the question first.

THE WITNESS: I recall the correspondence, yes. This is a copy of it not really a letter. This physician wrote in on what looks like a copy of his prescription pad a little note and enclosed what appears to be a copy of the New York Telephone Company Yellow page classified. This is a copy of my reply to him.

• • • • •

[4311] *By Mr. Bierig:*

Q. In this letter, Mr. Nortell, you state "There is no ethical prohibition by the Judicial Council of the AMA on a physician listing himself under a recognized specialty in the Yellow Pages of the telephone directory."

You also indicate that hypnosis is a recognized specialty. Are these statements in the letter an accurate reflection of the position of the American Medical Association at the time this letter was written?

A. Yes, they are. I presume that the inquirer had some question about whether or not hypnosis was a

[4312] medical specialty. It is.

It is a recognized medical specialty and could accordingly be used in a directory listing. That is an accurate statment of the AMA policy.

• • • • •

[4333] *By Mr. Bierig:*

Q. I show you now, Mr. Nortell, a copy of what has previously been admitted into evidence as Respondent

Exhibit 1, the Judicial Council's Opinions and Reports, 1977 edition. What was the last previous version of this 1977 edition of the Judicial Council's Opinions and Reports?

[4334] A. The edition that preceded this was December '71 edition.

Q. When did the Judicial Council first consider putting out new editions of the 1971 edition?

A. Well, as far as the 1977 edition I don't know if they considered it at any time prior to that time that I came on, prior to when I came on the scene. But it was initially considered, this new edition was initially considered at the first meeting that I attended as secretary of the Council and at several meetings thereafter. Initially it would have been in September of 1975.

Q. So the new edition was first considered September of 1975?

A. Yes.

Q. What happended subsequently?

A. Well, I don't recall whether any formal action was taken at that first meeting in September. I'm pretty sure that at the November 1975 that they were quite formal and definite about the fact that they wanted the new edition that would eliminate any of the inconsistencies or the ambiguities that were present previous material.

And well, just to give you a summarial overall, I can't say that after every meeting thereafter they considered it. Although I think they did consider various topics that were to be part of the booklet, rather up

[4335] until that time they finally approved this actual edition for publication which was in March of 1977. As I recall they would have considered it—the Council met in April of '76. They would have considered it at the annual convention in June of 1976. They would have

considered it and probably again particular items for it, probably new items.

I would say after that points were considered in subsequent meetings until finally at the March 1977 meeting the new format was completed. The items that they didn't want in there because they weren't current or legal problems with them or what have you were again—the new items that they didn't want in there were taken out.

Q. When was it, you testified, that it was first discussed in September of 1975. Then I believe you said it was first formally discussed in November of '75. Could you explain that a little bit more?

A. I don't have the minute book in front of me so I don't honestly recall whether or not there was an entry in the minute book that says the Judicial Council decided the edition or new edition of the Opinions and Reports. I know we considered at that time as I recall, at that first meeting that I was at, the Council considered it as part of the whole revision a new opinion or at least a new statement, a comprehensive statement [4336] on advertisement and solicitation.

I can't recall whether they took any formal action at that meeting. I do recall though that at the November meeting which was the one on November.

Q. This was November of what year?

A. '75. This was right after Thanksgiving when the meeting was held. I do recall that meeting that they did formally indicate that they wanted to have a new edition of the Opinions and Reports to accomplished the things that I mentioned. And it really is part and parcel of this type of method of proceeding. They wanted a report on advertising and solicitation.

Q. Why was it that the Judicial Council in the fall of 1975 perceived the need to put out a new edition of the Opinions and Reports of the Judicial Council?

A. Well, as is indicated on the first page of this booklet, as I may have mentioned before, there was historical material in the previous edition that was just obviously out of date, inconsistencies in the previous edition. There might be something on one page contradicted by something on another page because the items came up in a different period of time in the AMA Association. Much of the material was felt to be ambiguous.

Generally speaking it was not felt that the book represented the current policies or positions of the
[4337] AMA or of the Judicial Council of the AMA. In that sense the booklet really wasn't a usuable or current or practical reference. It was more a historical document and more confusing document than practical reference or help to physicians.

At the same time too, as I recall, the fall of 1975 I think, the Goldfarb decision was issued by the United States Supreme Court in the summer of '75, I think. I think it was just after the annual convention or maybe roughly at the same time of the annual convention of the AMA in 1975.

And, of course, as soon as that opinion was issued and we had obtained copies of it I sent out copies to the members of the Council. And as I did, by the way, with Bates case which was decided this year by the Supreme Court. We advised them to look at it and sit down and discuss at the next meeting how the changing legal considerations that were represented by these Supreme Court decisions would effect what they thought and the type of materials that they produced and what positions and statements should stay.

Q. You mentioned that Judicial Council as part of its overall revision was looking specifically at the question of advertising?

A. Yes.

[4338] Q. Could you explain why it was that in the fall of 1975 the Judicial Council was looking at the issue of advertising?

A. This had been a topical item in much of the literature, both the legal literature and, some if it is not really medical literature, but its publications that are directed at physicians is an area that should be of concern to the profession in the following Supreme Court decisions, in the Goldfarb case. Accordingly the Council thought that particular item was something that should be addressed and it was also a good vehicle to address a revision of the entire booklet on Opinions and Reports because it was equally concerned that there not be any legally inappropriate statements in other sections of the booklet anymore that would deal with the question of advertising and solicitation.

Q. You mentioned that the subject of advertisement was topical. I show you a copy of Respondent Exhibit 6 and ask you whether you can identify this document?

(The document referred to was marked Respondent Exhibit RX 6 for identification.)

THE WITNESS: Yes. This is a report of the Judicial Council that was adopted in December of 1974. It deals with the question of advertising of physi-
[4339] cians and health maintenance organizations or prepaid medical care type plans. This came up at the clinical conference in 1974 which was roughly in December, November—probably December, as I recall, of 1974 out in Portland.

It was quite obvious I think, even at that time that the question of advertising was something that Council would have to address in more contemporary terms than it had in the past. Trying to do that I think in

this report, trying as well to comply with more recent federal legislation in this area. That was the subject matter. I don't know if I mentioned it, but when the Council decided, when I took over the position in '75, to rework some type of basic or comprehensive statement on advertising and solicitation, this item was discussed among us, myself and members of the Council as indicative of the type of concern, I think, that this issue was presenting. This whole advertising and solicitation issue legally is one that I don't think was subject to much debate or discussion on the part of anyone. When I say anyone, I mean state legislature or medical societies or courts to any great extent for a long period of time prior to mid 1970.

At that time there was just a great deal more discussion of it in many arenas both, for instances, in the federal legislation and in reports. In the literature
[4340] at the Council meeting, and it was felt, it was time to put out something that was comprehensive and current and would be of assistance in this area.

MR. BIERIG: Your Honor, at this point we offer Respondent Exhibit 6 into evidence.

JUDGE BARNES: Any objection?

MR. LERNER: No objection.

JUDGE BARNES: I will received Respondent Exhibit 6.

(The document referred to marked Respondent Exhibit RX 6 for identification was received in evidence.)

By Mr. Bierig:

Q. Now, you mentioned, Mr. Nortell, that the issue of advertising had been discussed end of September

'75 meeting of Judicial Council. I show you a copy of what has been marked as Respondent Exhibit 627 A and B and ask you whether you can identify this document?

(The document referred to was marked Respondent Exhibit RX 627 A and B for identification.)

THE WITNESS: Yes. This is a two page letter I had written to Richard Burns who was, I am not sure if he still is, he was the legal council for the medical [4341] society in the state of New York. It was an interesting issue that was raised at the time.

The letter is from September of '75. He had written me in September of '75 when roughly contemporaneous with the time I assumed the position with the Council and first met with the Council in that capacity. He had written me concerning the question of advertising and anti-trust restrictions.

As I indicated in this letter, apparently the meeting of the Council was just before the issue was before the Council as I indicated to him after the last meeting. As I indicated here the restriction on professional advertising we intended to aim at circumventing the deceptive trade practices and that the Council had prior to this time issued records dealing with community directories and health plans and HMO's which is that report which you just saw there.

By Mr. Bierig:

Q. Did you in fact send this letter on September 29, 1975?

A. Yes, I did.

MR. BIERIG: At this point, Your Honor, we offer Respondent Exhibit 627 A and B into evidence.

JUDGE BARNES: Any obpection?

MR. LERNER: No objection.

[4342] JUDGE BARNES: I will receive Respondent Exhibit 627 A and B.

(The document referred to marked Respondent Exhibit RX 627 A and B for identification was received in evidence.)

By Mr. Bierig:

Q. I show you a copy of what has been marked as Respondent Exhibit 621 which is a page of which purports to be—I should say page 9 of the minutes of the Judicial Council meeting of November 29 and 30 of 1975. I have renumbered it. I have added a page which is a cover sheet so that it will be a little more clear on the exhibit now marked as Respondent Exhibit 621 A and B or 621 A being the cover sheet and 621 B being page 9.

I ask you if you can identify this document?

A. Yes. This is from the minutes of the Judicial Council of the meeting in November of 1975. This is just the heading and the call to order from the first page and a portion of page 9 of the minutes of that meeting dealing with the question of professional advertising and solicitation and the publication of the new edition of Opinions and Reports of the Judicial Council.

(The document referred to was marked Re-
[4343] spondent Exhibit RX 621 A and B for identification.)

MR. BIERIG: At this point, Your Honor, we would offer into evidence Respondent Exhibit 621 A and B.

JUDGE BARNES: Any objection?

MR. LERNER: Your Honor, our objection to this document is that excerpt from the minutes leaves out helpful context of other issues relating to advertising and solicitation that were also discussed at this meet-

ing and also, for example, on the page 1 cover sheet which was also excised, as I understand the AMA commended Edwin Holman for his many years of service in the AMA. For that reason I believe that the full context of that document is perhaps more helpful than just the excerpts on page 9.

MR. BIERIG: Your Honor, we had discussed this as you know, previously. Complaint Counsel had withdrawn its objection to, I believe, our proceeding in this fashion. And Complaint Counsel indicated that it has a copy of the full unexpurgated version of the minutes and is free to cross examine Mr. Nortell on those minutes.

I disagree with Mr. Lerner's characterization of this as omitting anything that is relevant to this issue. We perceive the information that is being offered as very relevant to the issue of the AMA's motivation in not publishing its statement on advertising of April of
[4344] 1976 and its revisions in 1977. And if Complaint Counsel wants to cross examine Complaint Counsel is free to do so.

JUDGE BARNES: Mr. Lerner, I believe you stated that the more complete version of this document is already in evidence.

MR. LERNER: That is correct, Your Honor.

JUDGE BARNES: What exhibit is that?

MR. LERNER: I believe it is 503, Your Honor.

JUDGE BARNES: I will receive Respondent Exhibit 621 A and B into evidence.

(The document referred to marked Respondent Exhibit RX 621 A and B for identification was received in evidence.)

[4345] *By Mr. Bierig:*

Q. Mr. Nortell, in the Fall of 1975, were either you or the Judicial Council aware that the Federal Trade Commission was investigating the position of the American Medical Association with respect to the issue of advertising or solicitation by physicians?

A. In the Fall of 1975?

Q. Yes.

A. No, I can assure you we had no awareness at that time. As a matter of fact, it came as a great shock to me personally when the F.T.C. filed a complaint in this case. I was out of the office at that time. It was at the end of the year in 1975. To be quite frank, all of the agencies that I or anyone else at the AMA thought would file a complaint against the AMA, of any of the federal agencies, the F.T.C. would have been the last one on the list. It was quite a shock.

We always thought that the positions of the Council were intended to be consistent with and supportive of Trade Commission policy in this area. It came as quite a shock to me.

By the way, I was out of the office at that time, and I didn't find out about it until a week or so after. I hadn't heard it on the news. A friend of mine, also a lawyer at the AMA, mentioned it to me when I was
[4346] over at his house. It was kind of funny because I said—he asked me if I heard about the suit against the AMA. And I said, "No." I said, "Who is suing us, the HEW, the Post Office, who?" He said, "No, the Federal Trade Commission." And quite frankly, I couldn't believe it. I guess I shouldn't stay so out of touch when I am on vacation.

Q. I show you now Paragraph 6.00 of the 1977 edition of the Judicial Council's Opinions and Reports which apears at Page 30 of the Respondent Exhibit 1, and ask you whether you can identify when that particular opinion was first issued.

A. Yes. This item, which is actually on Page 30 and a portion of 31, is the statement on advertising and solicitation. It was issued by the Judicial Council officially and formally at its April, 1976, meeting.

Q. And was this a statement that grew out of discussions that first began in September of 1975, and were continued in November of 1975?

A. Yes, it is. Previously, the Council had wanted to present a very thorough and in depth type of presentation by way of a report to the House of Delegates at the annual convention in '76. I believe that is what is indicated in the minutes from the Fall of '75.

[4347] However, it was quite apparent at the time that they wanted to act with greater urgency on this issue. They were as stunned as anyone else was that the Federal Trade Commission had filed a complaint in this case without any prior discussion or consultation or recommendations to the AMA of any sort. And subsequently, they felt it was important that this statement be issued at the earliest available time, which was their next regularly scheduled meeting, which was April of 1976.

Q. Now, since the issuance of the Opinion which appears at Paragraph 6.00 of the Respondent Exhibit 1, what has been your response when you received a letter of inquiry from an individual or medical society or any organization on the issues relating to advertising or solicitation by physicians?

MR. LERNER: Excuse me. Are you saying since the 1977 issuance of this statement, or 1976 issuance of the same language?

By Mr. Bierig:

Q. Since the 1976 issuance of this language?

A. Well, I am a little bit confused. The item was not issued in '77. It was issued in '76. This was merely a republication of the position on advertising and solicitation. But in any event, since that period of time in '76, April of '76, if someone writes in and says, "I want to know about advertising and solicitation for
[4348] a physician," or if they call up and say the same thing, my response is to provide them with a statement of the position of the Council on Advertising and Solicitation, or to refer them to the State Medical Practice Act in their state, and to advise them or to inform them that the state medical practice has to be considered in the light of the Supreme Court decision in the Goldfarb case, and for more recent correspondence and inquiries in the light of not only the Goldfarb case but the Bates case as well. But obviously, some of the State Practice Acts predate those Supreme Court decisions.

Q. Very well. I show you, then, copies of various correspondence that you have written since April of '76. Perhaps in the interest of time, I will show them to you as a group.

I show you now a copy of Respondent Exhibit 532, which purports to be a letter from you to a Dwight Allen, Executive Director of the Medical Society of Sedgewick County, Kansas.

Respondent Exhibit 536, which purports to be a letter written to you by Richard W. Hammer from Lincoln, Nebraska.

Respondent Exhibit 537, which purports to be a letter written by you to James Al Stallings of Montgomery, Alabama.

[4349] Respondent Exhibit 538, which purports to be a letter written by you to Richard C. Pembrook, of New London, Connecticut.

Respondent Exhibit 539, which purports to be a letter written by you to Walter Sorrell, M.C., of Montgomery, Alabama.

Respondent Exhibit 542, which purports to be a letter written by you to Edward M. Skovira, M.D., of Scranton, Pennsylvania.

And Respondent Exhibit 545(a) through (e), which purports to be a series of correspondence between you and Charles Hamilton, M.D., Chairman of the Ethics Committee of the National Academy of Medicine.

(The documents referred to were marked Respondent Exhibits 532, 536, 537, 538, 539, 542, 545(a) through (e) for identification.)

By Mr. Bierig:

Q. I ask you whether you can identify each of these documents?

A. Yes, I can, just very briefly. The first item that you showed me is a response to a question about a physician making use of announcements or an announcement card. I seem to recall this one. As I recall, this one had to do with an announcement in a newspaper or a card.

MR. LERNER: I can't hear.

[4350] THE WITNESS: As I recall, this first exhibit in this series had to do with an annuoncement in a newspaper and an announcement card about a change of office hours for a clinic practice. It is not a forbidden practice as far as the AMA is concerned.

The second exhibit in this series was dealing with specialty listings. I advised the physiciant that the AMA does—again, this gets into the mandatory question—does not authorize local specialty. But in any event, specialty listings are not a forbidden practice as far as the AMA is concerned.

The next item in the series is another one dealing with announcements. Again, this is an acceptable practice.

The next one is a stationery letterhead listing, also an acceptable practice.

Also, some minutes here of the Connecticut statutory law which contains standards on misleading or deceptive advertising. As I pointed out here, it is difficult for me to imagine how you could have a problem with this letterhead notation, which is like most letterhead notations with your name and address, phone number and what you practice.

By Mr. Bierig:

Q. When you say "the next one"—

[4351] A. RX-538.

Q. The previous one?

A. RX-537. And the ensuing one is RX-539. This one is also dealing with an announcement, basically the same as the others, indicating here is wellknown that the AMA does not provide sample forms.

Q. Sample forms on what subject?

A. On announcements. In other words, say your announcement must say X, Y, or Z.

Q. When you say "announcement," what do you mean?

A. An announcement would take any of several forms. It might be a newspaper announcement, in a brochure, it might be an announcement card that is

mailed out. It is announcing a fact of life. In this instance, it is announcing a fact of life. In this instance, it is announcing a fact that a physician is opening an office or closing an office or is going to be open different hours. As you know, any number of things, basic type facts of information that would be of interest to his patients. It would be any number of things that are covered in an announcement.

The next one is RX-542, the one about a Pennsylvania physician. This was just a general physician wanting to know what the position on advertising and solicitation was. He was given a copy of the '76 statement.

[4352] And there is what you might call a gratuitousness to it. I don't think it says anything in addition to the statement. It just says in terms of all misrepresentations on professional standards advisory statement should be given. It also refers him to the state law and suggests as I normally do, that he get in touch with local legal counsel because these are issues that are changing, and the statutory law from ten years ago may not be quite consistent with the current law.

Finally, this RX-545(a) through (e) is a group of letters dealing with the same issue as it relates to abortion clinics. The local Planned Parenthood Organization in Nashville indicated that they had unwed pregnant females in their office who wanted abortions, but just didn't know where to turn. The organization had written to the National Academy in Nashville, Tennessee, for their help. In turn, they had written to us and said, "Please would you contact these people, and would you tell them what the position of the AMA Judicial Council is on this." As far as advertising practices, I don't know whether they contacted them or not.

I did write back, though, and inform them that as to what the position was on advertising and solicitation. I also mentioned without citation—I can't say this is
[4353] one of my better legal letters, be that as it may. I did also refer him to a series of articles on the Seventy-third Supreme Court decision on abortion that had been previously printed in a Journal of the American Medical Association.

As well, I indicated that there certainly were more ways of making this information available that would be of assistance to the public. It was obvious this was a situation of an individual of the public who needed assistance. I pointed out to him, for instance, what the Planned Parenthood Organization in Chicago does, and it works very well with physicians in making known the availability of abortion facilities and services. So that really, on situations of young girls in that situation, they can receive the necessary medical care that they need.

Indicated also here that at least as I put it in my cursory review of the Tennessee law, it indicates that public service announcements by non-profit organizations in Tennessee are in no way a violation of Tennessee law.

Q. Let me ask you, was each oe of these letters which purports to have been written by you, in fact written and sent by you?

A. Yes. These were letters that I referred to that I received, or letters that I received, or items that I
[4354] received. And the letter here that indicates it was a letter sent out by me were letters that I sent.

MR. BIERIG: Your Honor, at this point, we would offer Respondent Exhibits 532, 536, 537, 538, 539, 542, 545(a) through (e).

JUDGE BARNES: Any objection?

MR. LERNER: Yes, Your Honor. My objection again would be all but one of these documents reflect what Mr. Nortell sent out in 1977, and not in 1976. And the one that was sent out in 1976 apparently had other enclosure as well as the 1976 statement which apparently were articles from JAMA having to do with abortion.

We have a continuing objection on that ground. I would also, for the record, indicate our position that the contents of these letters is best reflected by the letters themselves rather than Mr. Nortell's description and testimony of what he said in the letter.

JUDGE BARNES: I will receive Respondent Exhibits 532, 536, 537, 538, 539, 542, 545(a) through (e).

(The documents marked for identification as Respondent Exhibits 532, 536, 537, 539, 542, 545(a) through (e) were received in evidence.)

• • • • •

[4360] *By Mr. Bierig:*

Q. Now, you have mentioned, Mr. Nortell, that the 1977 edition of the Opinions and Reports which has been marked as Respondent Exhibit 1 was issued in April. When was it, sometime in 1977?

A. The entire booklet?

Q. Yes.

A. It was published and it was approved for publication in March.

Q. March of 1977. What was the effect of the publication of this document on the previous 1971 edition of the Opinions and Reports of the Judicial Council?

A. Well, the '71 edition will be removed from distribution. I think some time in '76, as I recall, we [4361] decided in the General Counsel's office, to just pull the item from distribution. And then, at the ensuing

meeting of the Judicial Council, we had asked for their approval of this action, which they gave.

I wasn't really using the book anyway, or the items that were in it, because there were too many problems with it. So the 1971 edition was not available for distribution at any time subsequent to roughly the middle of '76. I am not sure of the exact date. The '77 edition, of course, completely superseding anything that is in the '71 edition, or any other prior edition.

So, anything that is not in this edition that was in that anyone ever says was in conflict, they would just be wrong. That was there before in conflict, and is no more the position of the AMA on that subject.

Transcript of Testimony of
Michael Halberstam, M.D.
Tr. 7688-7735

[7688] *By Mr. Bierig:*

Q. Dr. Halberstam, will you please state your full name for the record?

A. Dr. Michael Halberstam.

Q. Where to you reside?

A. 2806 Battery Place, Northwest, in the District of Columbia.

Q. What is your occupation?

A. I am a physician.

Q. Where did you go to medical school?

A. Boston University Medical School.

Q. When did you graduate?

A. 1957.

[7689] Q. Could you describe your post-graduate medical education for the Court?

A. I interned at Montefiori Hospital in New York and then I spent two years in the Public Health Service in Alaska and New Mexico. Then I had a residency in internal medicine for two years.

Q. Where was that?

A. University of Vermont in Burlington, Vermont, and then I had a two-year cardiology fellowship at George Washington University here in Washington.

Q. When did you complete that?

A. In 1964.

Q. What did you do upon completion?

A. I entered private practice.

Q. Are you still in the private practice of medicine?

A. Yes.

Q. Could you briefly describe the nature of your practice?

A. Well, it is a standard private practice. I am a solo practitioner. I have a subspecialty interest in cardiology and about 50 percent of my practice is cardiology or heart potential related and the rest is general internal medicine. I am on the staff of George Washington University Hospital and Sibley Memorial Hospital.

[7690] Q. Are you board-certified in any particular specialty?

A. In internal medicine.

Q. What teaching positions, if any, do you hold?

A. I am an assistant professor of medicine at George Washington, clinical professor at George Washington University.

Q. Of what medical societies, if any, are you a member?

A. I am a member of the American Medical Association; the Medical Society of the District of Columbia; the American Society of Internal Medicine; the Institute of Medicine, which is an elective group.

Q. What is the Institute of Medicine?

A. It is the medical forum of the National Academy of Science, which is founded, really, to provide a policy-making and policy guiding national effort in the field of medical care. It is by election only.

Q. What offices, if any, have you held in any of these medical societies?

A. I don't think I have held any offices. I am a clear-cut failure.

Q. With what medical publications, if any, are you associated?

A. I am now editor-in-chief of "Modern Medicine Magazine." Before that I had been a contributing editor to the "Medical Economics Magazine." I am now on the

[7691] reviewing board of "The Annals of Internal Medi-

cine." I can't remember, there is one other, something called "The Journal Health and Society."

Q. What subject matters are covered in "Modern Medicine"?

A. "Modern Medicine" is a controlled-circulation magazine. It was the first of the controlled-circulation magazines. It is basically an abstracting magazine for physicians. It covers all aspects of medicine. There is small socio-economic component.

Q. What are your responsibilities as editor of "Modern Medicine"?

A. I suggest articles and I review the articles that are already written and I write two editorials a month for the magazine as editor.

Q. You mentioned "The Annuals of Internal Medicine," I believe?

A. Right.

Q. What were your responsibilities in connection with "The Annals of Internal Medicine"?

A. There, I am on the reviewing board. That is when they have manuscripts that deal with socio-economic topics, I am one of the people to whom they will send the manuscript for peer review.

Q. What writing, if any, have you done regarding the delivery of medical services in the United States?

[7692] A. I have done a fair amount. Actually, I have written so many articles that I tend to lose track. There have been a couple which I think are pertinent.

I wrote an article in 1971 for the "New England Journal of Medicine" called "Liberal Thought, Radical Theory and Medical Practice," which was, I think, a fairly important article, that has been anthologized in many collections about medical care.

In 1975, I was invited to speak before the Markel Scholars, which are sort of a select group of young

researchers and the paper I delivered there was later printed as "Personnel Care in an Impersonal Society."

And in 1973, I was invited to participate and give a paper at the Institute of Medicine in a seminar, not a seminar really, a large meeting that was held on Ethics of Medical Care, and my paper was titled, I think, "Medicine and Professionalism."

I have continued to write editorials regularly for "Modern Medicine" and I have done book reviews for the "New York Times" and the "Washington Post" and the "American Scholar," which is the journal of the Phi Beta Kappa Society.

Q. In what area were these book reviews?

A. In the field of medical care, particularly the socio-economics of care.

[7693] Q. What previous testimony, if any, have you given before the Federal Trade Commission?

A. This is interesting, I testified, I think they were administrative hearings that were held last year on advertising regulations, regulations governing advertising of over-the-counter medications.

The FTC was holding hearings regarding what could and could not be said or should and should not be said in mass media advertising.

Q. What was the nature of your testimony there?

A. At that time, I felt, I still do feel, that the advertising of over-the-counter medications was appropriate and that the proposed regulations were too restrictive.

I don't know how that came out either.

JUDGE BARNES: I think that is a trade regulation rule proceeding.

MR. BIERIG: Yes, I think it is.

By Mr. Bierig:

Q. Have you had occasion to consider the implications of advertising by physicians for the practice of medicine?

A. Yes, certainly.

Q. And have you had occasion to consider the implications of advertising by physicians for the concept of professionalism?

[7694] A. Yes.

Q. How did you happen to consider these subjects?

A. Well, as I said, I have been involved in thinking and writing about the sociology of medicine for as long as I have been practicing.

My undergraduate field was history and I had some experience as a journalist so that when I started to practice medicine, I was naturally interested in not only the technical and scientific aspects of what I was doing, but its professional and sociologic implication and I had already written a paper, a scholarly paper for the Institute of Medicine on the issue of professionalism as it affected the delivery of medical care. And then when the issue of advertising came up, I was naturally interested in that.

Q. In your judgment, Dr. Halberstam, what effect, if any, would advertising by physicians in newspapers, radio and television have on the practice of medicine?

A. I can't help but feel it would be a deleterious harmful effect.

Q. When you say "harmful and deleterious"—

A. Harmful to patients and to society in general.

Q. How would this be harmful to patients in society in general?

A. Well, I think it would be harmful to patients

[7695] because I can't think of any way in which advertising could be done which would do more good than harm.

That is, if one were to put out "objective standards" of care suggesting that physicians report the number of cases of a certain thing, a certain condition that they have treated, then advertising would inevitably force—not force—but push physicians to treating more of a particular case, even if they didn't have the needed experience.

If you advertised, permitted the objective advertising of what a surgeons mortality or complication rate would be, the surgeon would tend not to operate on the sicker patients and would tend to do more and more cases of an easier nature on people who might not necessarily need that surgery.

And I think its inevitable that advertising would be extremely difficult for a consumer, patient to evaluate.

Q. When you say it would be "extremely difficult" for a patient to evaluate, could you give examples of what you mean?

A. I think one of the things which would be suggested in any kind of advertising would be that people put down only objective data, such as the institutions that they belong to or the organizations that they belong to, but it is extremely hard for physicians to
[7696] know the importance of medical groups and medical societies any medical institutions that other physicians in other specialties belong to.

I think it would be impossible for the lay person to evaluate the difference between, let's say, theoretically the World Conference of Surgeons and the American Conference of Surgeons. There would be listing of honors and prizes and journals which would, for the lay person, be impossible to evaluate because for the professional they are very difficult to evaluate.

Q. What effect, if any, on the practice of medicine will you see in something like the objective advertising

of the number of operations that a physician has performed?

A. As I say, that would, I think, inevitably tend to heat up the physicians desire to accumulate a large string of operations and because in surgery, as in a lot of other parts of medicine, there are judgment calls, there are often things that are neither black nor white but on the mid-line.

If a physician is being judged publicly on the number of certain procedures that he has done and he knows that is going to be public knowledge, if he is not quite sure whether he should operate on this case, I think the fact that is going to be public knowledge is in-
[7697] evitably going to influence his or her decision to operate in that case.

Q. In your judgment, Dr. Halberstam, what effect, if any, will advertising by physicians in newspapers, radio and television have on the nature of professionalism?

A. Well, I think, again, it can't help but erode and eventually I would suspect destroy the concept of professionalism. I think there is a really important and significant difference.

I believe in business, some of my best friends are businessmen, but there is, in fact, a difference between professionals and businessmen and it is clear that the object of a business is to maximize profits through both, through either, providing an increased number of services or increased number of sales or increased cost of those services, or both, actually, whereas one of the touchstones of professionalism is the fact that one is not trying to maximize one's profit or one's income.

Now, it is clear that there is a business aspect to a profession. I do not think that is deniable, but one of the major criticisms that has been made of American

medicine—not just American medicine, but medicine in other countries, too— is that it has been too much like a business. I do not really think that is true.

When people say it is too much like a business, they
[7698] mean that physicians are too intent upon maximizing profit.

It seems to me that by accepting and encouraging the concept of soliciting patients, one inevitably, over a period of time, not instantly, changes the professionals role from someone who spends much of his time turning away clients, turning away patients, turning away potential builders, as architects do, from one who will almost always accept people who want one's services.

I am not talking about, in this context, merely about physicians, but it is true, certainly of lawyers. It seems to me people come to lawyers—I have come to lawyers and I have said, sue the son of a bitch and the lawyer said, well, I don't really think you have much of a case. You are really going to be wasting your time and your money. And I have thought about it and I think the gentlemen was correct.

What I do as a physician, what I think many other physicians do because I covered their practices and I have spoken to patients from all over the United States, is to turn away people who think they need medical care because the physician has made the judgment there really isn't an appropriate use of the patient's time or money that medical care is not what is needed. We hear that all the time.

[7699] People say, I called the doctor, I wanted to come in and he said no, just take a couple aspirin and stay in bed for a day. I have been doing that a lot during the current flu epidemic.

It seems to me that by advertising, by encouraging subtly but differently a business mentality which says,

do as much volume as possible and bring in as much business as possible, you lose this gate-keeper function of the professional, the responsibility, not just to maximize the number of people you see, but to see them appropriately and to turn away a large number of people who want your services.

Q. What implications, if any, does this shift in the nature of professionalism that you foresee have for the patient?

A. I think that the patient over the years—I am pointing out this would be a change that would not occur immediately. It is going to be a change that would occur over generations. The patient is going to lose confidence in professionals and physicians in particular if this business mentality is encouraged.

Q. Why do you say—

A. Because a large part of what, in the medical relationship, a large part of what goes on between doctor-patient results out of a mutual trust. You can-
[7700] not show the patient something that you are going to sell him. There is no television set to set before him and say, here, this is what you will buy and we will service it and so forth.

You are promising that patient a series of services, most of which are intangible and you are asking the patient to embark on a series of treatments which may be expensive or painful or even dangerous.

And the confidence of the patient in going through a protracted series of treatment is depended in large part on his confidence that the physician is not motivated by primarily pecuniary interest, that he feels there is a pecuniary interest involved, certainly, but that that is not a significant part of what the physician is doing.

And if the patient feels that medicine is a business like any other business, the patient will be much less inclined to go and get medical care which is, in fact, necessary, because he will feel, well, he is just trying to sell me that operation because he is just like any other business and he needs the money, and he is just trying to run up a string of cases.

We know that criticism exists already. It seems to me it would be unlikely that advertising would do anything but to encourage it and accelerate it.

Q. What effect, if any, would advertising by a [7701] particular physician have on the practices of other physicians who do not advertise?

A. Well, I think, again, that over a period of time, it would be put increasing pressure on nonadvertising physicians to advertise.

How, again, the models there are not complete and we do not have very good information, but it would seem to me that as younger doctors come along and see that advertising is accepted or encouraged or required or whatever, that they will advertise as a matter of course, that advertising will become more frequent and that the cost of the course of that advertising is going to be brought back again to the patient.

In that sense, the cost of advertising will be directly borne by the patient or by the society in general, whoever is paying for medical care, and that in addition to that, it can't help but heat up the demand for medical services, some of which may be not necessary for the patient.

Q. Could you explain what you mean by that, Dr. Halberstam?

A. We already know that there is criticism of the medical profession about unnecessary surgery, about

unnecessary hospitalization, about unnecessary—even coronary care units have said to be unnecessary.

[7702] I think, again, that much of that criticism is unjustified, but there is some unnecessary surgery, there is some unnecessary hospitalization, and by adding, bombarding the public with commercially designed advertising, it seems to me that one can almost conclude by definition that the demand for medical care is going to increase and that some of that demand is going to be for unnecessary services, and that the inevitable tendency will be to accommodate patients who want services provided but who in the past would have been turned down.

We are pointing out—I am pointing out—that the demand for medical service, in almost all societies, exceeds the supply, even if the supply of physicians in this country is increased, the demand will probably still be very high. And that the demand for medical services is not necessarily correlated with good health and that the heating of demand by advertising will, for every necessary service which might previously not have been rendered, will generate a larger number of unnecessary services.

And I do not think that is because of the "dishonesty" of physicians. I think that will occur because of two things. Because patients want these services, as we have said before, and because with advertising, physi-

[7703] cians will be losing their gate-keeper professional function of turning away people and saying, well, if they want these things, we might as well see them.

Q. What effect, in your judgment, Dr. Halberstam, if any, will advertising in newspapers, radio and television have on the distribution of information that will help consumers to make a more informed choice of physicians?

A. Very little.

My feeling is that aside from the fact that the cost of that advertising is going to be passed on to the patient, that the informational aspect of advertising in that context is minimal. I don't know of any consumer groups that have actively lobbied or pushed for advertising on the part of physicians. I do not know of any major theoreticians of health care who have pushed for advertising on the part of physicians, and I do feel that information is available in large amounts to the American public about medical care and that information provided by advertising of a professional service is, in terms of the information value, negligible when contrasted to the risks involved.

For example, again, we realize that professionals themselves have very little ability to evaluate the paper credentials of other physicians, of people out-
[7704] side their own specialty. As an internist, I really don't know the prestige rank of the major surgical societies. I don't know which are the ones you can join by taking an examination and which one you can join after completing two years of post-graduate study and which ones you can join after completing two weeks of a seminar. There are all sorts of surgical groups.

And as a physician, if I have trouble evaluating those paper credentials, then the consumer herself is going to have even more trouble.

Q. You mentioned that you believe a lot of information is already available; what did you mean by that, Dr. Halberstam?

A. There have been a number of studies of attitudes about health in the United States which indicate that people are—we are talking about all classes of society—are very much aware of the proper times to

see physicians. They are ware of what symptoms are significant symptoms. They are aware of what specialist to see and if we look at the mass media in this country, we will see the mass media presuppose a rather marked sophistication on the part of the public about medical care.

I did an article for the "New York Times Magazine" in 1968 about the physician as he appeared on television, and that was a time when both "Ben Casey" and
[7705] "Marcus Welby" were leading programs.

For part of the program, I had ABC send down six of the Marcus Welby programs on tape and I reviewed them. I had seen some of the others, but I just took six and went through them in a series of three mornings.

Marcus Welby was the number one program that year. It was amazing how much sophistication the programs assumed of the watching public and how much better these programs were than the programs of the 1930's. The radio programs or even the plays in the 1930's always, if they had a medical theme, always ended with a new operation that had just been brought in from Vienna or a miracle drug or a mysterious illness, and Marcus Welby never did that and the illnesses were never mysterious like lupus or epilepsy or other recognized, although occasionally rare illnesses.

The other thing that was striking about them was not only the amount of sophistication that they presupposed but the amount of actual teaching that they did. People really learned, and I cannot accept the fact that the American people are unsophisticated about the mechanisms of medical care, about what treatments are appropriate, what treatments are inappropriate.

In fact, even in the current controversy about laetrile, I think people are displaying a fair amount of
[7706] sophistication.

Q. Where, if at all, can consumers currently get information on how to choose a particular physician?

A. Well, I think one of the clear-cut things to do is to call physicians. I am not aware of anything which indicates that physicians themselves do not give information about how they practice. But I think the movement towards physician directories is an appropriate one, and I think as contrasted to mass media advertising, the physician directory is a way of getting informational data to people who want it and who feel in need of it.

Q. What distinctions, if any, do you see when listing physicians and facts about these physicians in a directory on the one hand as opposed to advertising in media such as newspapers, radio and television?

A. The most striking thing is, of course, the people who use a directory are already motivated to seek medical care and to find out more about the people in the institutions that provide it. It is not a method of heating up demand for people who had not already been interested in seeing a physician or having a certain condition treated. The directory presupposes an individual who is thinking in terms of medical care but wants to find out some more objective data.

And furthermore, it seems to me a directory can, [7707] even if it is put out totally by nonphysicians, can at least have someone in charge who will be able to evaluate the objective data in terms of what organizations, for example, are more important for surgeons to belong to, what kind of affiliations are more prestigious than others as opposed to a newspaper or mass media advertising where no one can say when it says "World Congress of Surgeons," then no one puts in a little thing down underneath that this organization can be joined by attending a one-week seminar in Hawaii

every other year and completing a very simple test at the end of the seminar. That kind of information can, however, be provided in a directory.

Q. What distinctions, if any, do you see between directories and mass media advertising in terms of costs to the system?

A. Well, the other thing I should have pointed out clearly is that advertising is expensive and mass media advertising is particularly expensive, and that, as I have said earlier, I can't help but believe that over the years nonadvertising physicians would be pushed towards a position of advertising. That cost is going to be borne by the patient and by the society in general, whereas in a directory, the cost is borne only, the cost is much less and is borne in general by those who are
[7708] particularly interested in that information.

Q. What distinction, if any, do you see between a directory and mass media advertising in terms of their effects on the practice of medicine? You listed earlier possible deleterious effects that you saw.

A. Again, I think the concept of professionalism is a valid one, and the function of a professional, whether he is a lawyer or an architect or a physician, to say you don't need a lawyer or an architect or a physician is an important one.

And that advertising in mass media can't help but destroy—let me give an example. If someone advertises discreetly, just with his name in the "Washington Post," quarter-page ad every week for a year, Michael J. Halberstam—let's use an unimaginative person, Michael Halberstam, cardiologist, these are the office hours, these are the societies, it seems to me very hard to believe that that person will turn away a patient that comes and says, look, I want to see; doctor, I want a complete workup. I have got such and such a problem and I want to see Dr. Halberstam.

We turn away patients all the time now. It seems to me it would be very hard under that system to turn away patients and say, no, you don't want me, you want another doctor or you had a workup a week away at
[7709] Johns Hopkins. We don't want to see you.

A directory, on the other hand, by not heating up the demand for medical care, by not putting the physician in the place of a businessman who is trying to maximize the number of people he sees and the amount of profit he makes, a directory is a much more professional way of getting information to the consumer without eroding that position of a gatekeeper, without eroding the concept of professionalism and as I said without increasing the demand for medical care which is latent in a lot of people but which advertising itself would heat up and in most cases inappropriately.

I should point out in looking this up, in thinking about this subject, I looked through a whole series of recent books about medical care in America and except for one of them they are largely unfavorable. Most of the books that have been written about medical care in America have been critiques and have titles like "Crisis in American Medicine," things like that, and in none of them is advertising by physicians suggest—

MR. WRIGHT: I am going to object to the witness testifying what is in the books. I am making an objection. It may not be sustained. I am going to object to the witness giving his opinion. I think he has given what his background is.
[7710] I think Your Honor can see what the basis of the opinion is.

JUDGE BARNES: That is what he is telling you now. He read these books and none of them bring up certain matters. I think that is proper testimony.

MR. WRIGHT: I don't mind if that is flushed out in terms that this is his opinion based on certain readings. But if he is going to get into telling us what is in the books, I think it will become a problem.

JUDGE BARNES: It may become a problem, but I don't think it has reached that yet.

By Mr. Bierig:

Q. Do you want to continue?

A. There is a book by Ivan Illich called *Medical Imminence,* a book by Rick Carlson called *The End of Medicine,* a book by Sielig Greenberg, the title escapes me at the moment.

There is a very recent collection by John Knowles of the Rockefeller Foundation called *Doing Better and Feeling Worse.* It is a collection of 18 essays on health care in America by nationally and internationally known leaders and there is one by Dr. Lewis Thomas, who is the dean of the Rockefeller now. It is called, I think, *The Rockefeller Medical School,* who points out—his only mention of advertising is that ethical
[7711] advertising, what we now accept as ethical advertising in this country, that is advertising by the American Heart Association, the American Cancer Society and other such groups, has primarily added to the cost of medical care and the burden of illness without significantly improving the health of the American people.

And his point is that this kind of advertising, ethical advertising by nonprofit organizations has laid on the people a burden of neurosis, a feeling that we are born ill and have to be made well rather than the other way around, and that it has escalated the cost of medical care inappropriately by flaming the demand for medical care through this kind of nonprofit advertising.

I can't help but feel when that kind of advertising, even truthful, dignified advertising, is extended to the professional themselves, that same net effect won't occur. And a directory, on the other hand, because of its informational value, because of the fact it is available to people who have already made the decision to think about medical care, would not have those side effects.

Q. Dr. Halberstam, have you had occasion to consider the implications for the concept of professionalism of a rule which would preclude medical societies from regulating the advertising practices of their members?

A. Yes, I have.

[7712] Q. And how did you happen to consider this subject?

A. Well, again, because it flows out of the very nature of thinking about advertising itself and professionalism itself. If there is going to be advertising, who is going to regulate it? Certainly I have written about the subject and I have testified earlier at other hearings and I thought about a fair amount about advertising.

Q. In your judgment, Dr. Halberstam, what implications, if any, are there for the concept of professionalism in a rule which would preclude medical societies from regulating the advertising practices of their members?

A. It seems to me that would be disastrous. If the regulation of advertising were taken away from the profession, it seems to me to erode the very concept of professionalism itself. If there is any validity to the concept of professionalism—I think there is.

I have read the works of Alfred North White. He wrote abuot professionalism. There is a friend of mine

named Kenneth Lane Lynn who wrote about professionalism. It seems to be generally accepted that professionalism is a good thing.

If there is anything that would be erosive to the very nature of professionalism, it is the idea that a profession cannot govern its members and what they do publicly.

[7713] We are already told in medicine that the profession has to govern itself more appropriately and even Mr. Califano says, if you guys don't do it, we are going to have to do it for you, but you have to do it yourself because we can't do as good a job of it. He is not talking in that context about advertising, but he is talking about other aspects of professional governance.

It seems to me if there is to be advertising, that it is a very direct professional activity and it should be regulated by the profession itself. I can see where there might be Federal or local impingements upon that self-governance, but it would seem to me will be axiomatic. If there was to be regulation, it would have to be done primarily by the profession itself.

Q. And why do you think it would be axiomatic and would have to be done by the profession?

A. Because it seems to me so simple that it is very hard to explain. If you say that you are a profession and you are an independent group and we have granted you professional autonomy because you have a specific body of knowledge and a specific public function that requires the kind of expert knowledge that the rest of society can't easily evaluate and because of that we are giving you the semi-autonomous status of a profession, that if you do that with one hand and say but,

[7714] on the other hand, your public utterances cannot be regulated by yourselves but by a Federal or local or state governmental society, that you are free to go

any place you want and do anything you do so long as you walk in a straight line and it is between 8th Street and 11th Street, you are saying that you are a profession on the one hand but you are taking away one of the major forms of professional autonomy and governance away from that profession, and that in a more theoretical sense—this was something I think was very clear during the 1960's and early seventies, in the radical movement in the United States and in the professions themselves, that whether one is a left-winger or right-winger, the idea of a profession that has some autonomy outside the Federal government is a very valid one.

And Paul Goodman wrote very extensively and very eloquently about that, that there have to be institutions, religions, professions, that are not immediately accessible to state control.

There is a state interest, there is a state interest in religion. The business, for example, of tax exemption. There is always a state interest in religion. But we still say the EEOC is going is not going to determine whether or not there should be female priests.

I think we grant this concept of independent forces
[7715] to religion. We grant it to professions because we know instinctively, I think as the people who wrote the Constitution knew, there have to be independent organizations, independently organized groups within society and that society in general does have a vast interest in seeing that these other groups do not infringe on the most basic rights of citizens, that is, even though we grant freedom of religion, we would, I think, look with disfavor on a religion that practiced child sacrifice.

We did, in fact, I remember there was a series of cases involving the Jehovah Witnesses and what they could and could not be required of as citizens.

But we have in general said the amount of regulation we are going to require of religions is very little. And we have said the same thing about professions. And I think for equally valid reasons.

We have said we really do not know that much in terms of regulation. We really do not know that much in terms of scientific information. We can't make those decisions as a governmental group. We are going to have to grant you people some autonomy just as we grant the autonomy to the scientists in most cases.

As in medicine, as in science, as in religion, there are times when in issues of such where governmental policy
[7716] is directly effective. The predominant DNA in science is one.

In general, the government stays out of the laboratory and is saying we really do not have enough knowledge, you are going to have to judge this on the basis of your peers, just as the Congress makes its own rules and says, well, we know there has been a lot of criticism of seniority, but we know how to govern ourselves best in that regard.

And I think with professions, the concept of self-regulation of its members, primarily self-regulation by the profession of its members is crucial and that the regulation of public expression, advertising or soliciting, is a very crucial part of that. If you deny that, you deny, in many ways, the fundamental tenants of professionalism.

MR. BIERIG: No further questions, Your Honor.

MR. WRIGHT: May we have 5 or 10 minutes, Your Honor?

JUDGE BARNES: We will take a five-minute recess.
(Brief recess.)

JUDGE BARNES: On the record.

Cross-Examination

[7717] *By Mr. Wright:*

Q. You have been a member of the AMA since approximately 1968 or '69?

A. About then, yes.

Q. And a member of the local medical society since 1964?

A. Right.

Q. Is that the District of Columbia Medical Society?

A. Correct.

Q. And that is a component society of the American Medical Association?

A. Correct.

Q. Doctor, isn't it true you have no economics background?

A. Yes, that is correct. I mean no academic formal economics background, right.

Q. Isn't it also true that with respect to your statements here today on direct examination, with respect to physician advertising and its effects, that this is your own personal opinion?

A. Well, there are two things. It is my personal opinion—three things, I guess. It is my personal opinion. It is the opinion of other people whose remarks I quoted and it is also my personal opinion in the absence of any other evidence to the contrary.

I have studied the field fairly extensively and I [7718] cannot find very much about what happens when physicians advertise except, of course, we know what happened when they advertised 90 years or so years ago. It seems to me the whole field is based on speculation and if there is evidence of a beneficial effect from advertising I haven't seen it.

I don't know of any change in medicine that is as fundamental as this one which has been proposed with so little objective evidence in favor of it. I have really looked.

Q. Are you purporting then to have done a comprehensive study—

A. No, I haven't.

Q. Isn't it true though you have not done any formal or systematic study yourself with respect to advertising?

A. No, that is correct; I haven't. I do know, of course of some work which has been done on consumer attitudes and directories, being a very formal study by the people—two guys at Princeton. Leroy Schwartz and a fellow named Cunningham, who as part of Cunningham's senior thesis at Princeton called 50 randomly-selected physicians in New Jersey, 25 in an upper-middle class neighborhood and 25 in a lower class blue-collar neighborhood asking for practice information over the phone. The found out that the physicians
[7719] and their assistants gave this information very readily over the phone.

They identified themselves as Princeton investigators. They said they were potential patients; did the doctor make house calls; how much did he charge and so forth. They did not identify themselves.

Cunningham's thesis got him honors at Princeton and it has been reported and I guess it is going to be the basis for some additional studies.

But I have looked for similar studies. I am not aware of them.

Q. You haven't been a member of any medical societies' ethics committees, have you?

A. No.

Q. You have no firsthand experience with respect to AMA or medical societies' enforcement of ethical tenets?

A. No,

Of coure, I am aware from what I get from the AMA and from the local medical society about some of the issues involved in ethics, particularly as it pertains to advertising.

I would point out, by the way, that I am an invited speaker at the American College of Physicians which is perhaps the most prestigious organization of internists. I am an invited speaker at their annual meeting
[7720] this coming April on the ethics panel, although, again as I say, I have done no systematic research on the field.

Q. Doctor, your father and uncle were physicans also?

A. Correct.

Q. Isn't it true that from the time you were a child you were made to understand that doctors don't advertise?

A. That is correct, right.

Q. Doctor, you wrote an editorial for the "Journal of American Medical Association" in approximately, I think it was 1973. Did you not state in that editorial that in your opinion the AMA is a clumsy outdated cross between a trade union and a tissue review committee?

A. Was that in AMA—

MR. BIERIG: Your Honor, I am going to object—

MR. WRIGHT: State Medical Journal.

THE WITNESS: I think that was reprinted from someplace else.

JUDGE BARNES: Where did it appear?

MR WRIGHT: I am sorry, Your Honor. Give me one second and I will try to see where it was reprinted from.

This article appeared in November 1973 issue of the "Maryland State Medical Journal," and it originally appeared in the November 20, 1972 issue of "Medical Economics."

[7721] THE WITNESS: Yes, that is right. The Maryland State Society reprinted that.

By Mr. Wright:

Q. Yes, it did.

A. It goes to show there is a lot of self-criticism.

MR. WRIGHT: May I proceed?

MR. BIERIG: I withdraw my objection.

THE WITNESS: I said I did write it. I did say that, among other things, I guess.

By Mr. Wright:

Q. You also stated, referring to your father and uncle, referred to them as liberals both and that they felt the association, that is the AMA, was a reactionary dinosaur fighting against good medical care. You stated I think they were correct?

A. Yes—

MR. BIERIG: Your Honor, there is no time frame when the father and uncle said this and what they meant.

JUDGE BARNES: And there is no time frame on whether the doctor thought his father was right, whether he thought that some years ago or whether that is the witness' opinion now or at the time you wrote this article. It is a little unclear.

By Mr. Wright:

Q. Was that your opinion as of the time of the article?

[7722] A. No, my opinion at the time of the article was that at the time that my father and uncle thought the AMA was a reactionary dinosaur, that was mostly during the thirties and early forties, they were correct.

Wasn't that article entitled, something, "Why I Finally Joined the AMA"?

Q. Yes?

A. Sure.

Certainly at the time I wrote the article, I guess that was in 1972, I did not think the AMA was a reactionary dinosaur or I don't think I would have joined it. But It did indeed feel during the 1930's and early forties it was. I think my father and uncle were correct.

Q. Doctor, you also stated that "I was an idealistic student when the AMA mounted its multimillion dollar public relations campaign against Harry Truman's medical care bill," When was that?

MR. BIERIG: Objection, Your Honor.

I don't see what relevance the AMA's action— assuming there was one and the witness has not been qualified in the AMA action during the administration of Harry Truman, and even if he were, it would seem to me what the AMA was doing from 1945 to 1952 would have marginal relevance even to the case in chief and certainly has no relevance at this point.

[7723] JUDGE BARNES: I think the witness' testimony was limited to advertising and now you are going into legislative efforts or positions of the AMA on Medicare or Federal government medical programs which is not related to his testimony.

MR. WRIGHT: The point we are trying to make, Your Honor, is the witness here today has given extensive opinions with respect to advertising in the medical profession generally and those opinions, of course, are based on his own particular outlook. We are exploring what that outlook is, not only with respect to physician advertising, but with respect to the AMA, too. Because it does tie in.

He is purporting to state here the AMA should be the one to, one of the ones to self-regulate the profession. And his view of the AMA is relevant.

JUDGE BARNES: Self-regulate the profession in terms of advertising and ethical conduct of its members, not its legislative program.

MR. WRIGHT: Our contention is intimately tied in with that. It is if these restrictions have economic impact upon the profession and if the witness' feelings were such he feels that is an appropriate role for the profession to take, I think it is relevant.

JUDGE BARNES: I don't think so and especially [7724] what happened in 1945 or 1952. On that specific question, I am going to sustain the objection.

By Mr. Wright:

Q. Doctor, are you familiar with the current AMA position with respect to physician advertising?

A. Yes, fairly. I am not the world's greatest expert on it, but I think I am familiar.

Q. Isn't it true that position currently purports to allow factual advertising by physicians?

A. I don't think it purports, I think it does.

Q. So your position then would be more conservative than the AMA's?

A. Well, let me make a distinction there between what I think is legal or appropriate and what I think is personally distasteful.

I think that it is, indeed, appropriate and ethical for physicians to make announcements to the population in general that their services are available and that has always been, I think, the policy of the AMA even though in the eastern part of the country, physicians really did do that.

It was certainly true that in many small towns you would see little advertisements saying that Dr. Charles Johnson announces the opening of his office for the practice of obstetrics and gynecology and such and
[7725] such a thing and that was always accepted.

I accept that and I find it ethical and appropriate and, in fact, informational.

The question of how often those advertisements should run, how big they should be is, as they say in the National Football League, a judgment call.

All I know is, I can't make a decision about what is ethical, but there are certain advertisements that I find distasteful. Even though the AMA might find them ethical, I wouldn't like them.

Q. Doctor, do you know whether consumer directories regarding physician services which are referred to have been—which have been published—have been widely distributed to consumers in the respective pertinent areas?

A. I have spoken to Dr. Schwartz, who I mentioned earlier, and I have read one or two brief mentions of that and my feeling has been that even consumer directories, which I think are appropriate, have not been wildly successful.

I think, and I will quote Dr. Schwartz on this, that he knows of none which have gone into second editions.

Now, I know personally in the District of Columbia there was a great deal of initial concern about the Prince George's County Directory because that was the

[7726] one which had impetus coming from Ralph Nader's people and there was initially a lot of resistance on the part of Prince George's physicians because they felt, and I suspect correctly so, that it was sort of an adversary proceeding, that the people who were compiling the directory didn't love physicians all that much and had been identified with a lot of criticism of physician and therefore physicians were reluctant to cooperate.

But apparently that has been smoothed out but I don't know of any and Dr. Schwartz confirms this, which has gone into a second edition, which I think tend to confirm my feeling, at least not tends to confirm, but tends to bolster my feeling, that the public has the information it wants already. It has other ways of getting the information other than the directory.

Quite frequently I think people ask their friends, which I think is the single most appropriate way of finding good medical care or apropriate medical care.

The fact that directories in my estimation have not been very successful doesn't mean that the concept of a directory is bad, it just means that the need for them was exaggerated.

Q. You are a sole practicer, are you not?

A. Right.

Q. Do you have a list of routine or basic fees [7727] available to your patients?

A. We do, right.

Q. What items would be included in that list?

A. Cost for an initial physical examination, which is probably the most variable cost; the cost for a routine office follow-up visit; the cost for and electrocardiogram, X-ray and standard laboratory work.

I do not have that printed up. I do have a patient information booklet printed. In that I talk about my fees and say we are glad to give them out and so forth.

The only reason I don't have them printed is because they change more than my hospital affiliations and other aspects of my practice change. They do not change that much, but it seemed somehow they are less concrete than the other ways, other aspect of my practice.

Q. Those are your usual and customary fees?

A. Yes. There is a tremenodus variation. I think that is one of the problems, by the way, in advertising, services as opposed to goods. The fee for my initial physical examination runs from anything from $25 to $75. Someone comes in and says, I want a physical exam and my nurse does all the scheduling and she has some guidelines from me about what, in general, to do, but someone comes in and says I want a complete history and physical and it turns out to be 19 year-old
[7728] kid who is about to go to college, it can be done in a very short time.

I certainly don't charge that person the amount that I will charge a 75 year-old man who has a great laundry list of complaints and who takes an hour to get through his initial history. So there is that great variation.

After the initial visit I can pretty much estimate how much time and complexity is involved.

Q. Could you give examples of other visits beyond the initial visit?

A. Yes. There is a routine office visit, I code it 9150, which is $20, which is for someone who has come back with a complaint or whom I have asked to come back to be checked up on something and where there is some exchange of problems and information and examination.

I have a brief office visit coded 9140, which is $15 for people who just are coming back to have their blood pressure checked or who are trying to lose weight and who want to be weighed regularly and feel they can't lose weight unless the doctor is standing over their shoulder or people who have a little thing on their finger that they want looked at.

Then there is 9160 which is an extended office visit in which there is a return visit by a patient which turns out to be much more complex than the average return.

Q. What would your usual customary fee for that be?

[7729] A. $25.

Q. Do you also have electro-cardiogram fees?

A. Yes.

Q. What would it be for that one?

A. The electroc-cardiogram is $22.

I would point out that it was $20 until I found out that the hospital was charging $25. This an example in which dissemination of fee information tends to increase fees as much as it tends to decrease them. Again, I see no evidence to suggest it would go the other way around.

Q. What other tests would you have a usual and customary fee for?

A. There is a battery of test called the SMA 12, which are 12 tests that are done on an automate machine. The fee for that is $15. A complete blood count is $7. Urinalysis is $3.

Q. Do you have a nurse or office assistant that does your billing?

A. Yes, she does part of the billing and then I have a little group that comes in once a month to send out the actual bills.

Q. Do they use this list in doing the billing?

A. Yes.

Q. Is this list also utilized for insurance company
[7730] reimbursements?

A. Yes, right.

Q. Then if a patient calls and asks for a fee from your nurse or your assistants, they will quote that usual customary fee?

A. Yes, right.

Q. Doctor, you describe an information booklet you give out to your patients?

A. Yes.

Q. This is not given out to prospective patients?

A. Correct.

Q. What types of information would you put in that booklet?

A. I really like that booklet a great deal. In fact, I wrote an article suggesting that other physicians do the same thing. It is the sort of thing that pediatricians do, but internists in general have not done it. I told them what hospitals I use, what the procedure is in an emergency, what my procedure is about phone calls.

I think one of the major problems in practicing medicine is handling of phone calls. I handle many more patients by phone than I do in person each day and patients who call, I think, understandably get annoyed if I don't call them back within a couple hours.

I have to explain in the booklet I am seeing real
[7731] live human beings in front of me and they have precedence and I can't keep leaping up from the desk to answer the phone. I will call them back at the end of the day. If it is an emergency, let me know. I tell patients what it is an internist does.

The major complaint I have had from patients is the fact that they came in to see me for the first time

just with a sore throat and I did a complete examination and why did you bother to take my blood pressure and listen to my chest and so forth when all I had was a sore throat. I have to explain to people that internists work in that way.

If you are seeing someone for the first time, first of all, a localized symptom may be part of a generalized disease. Second of all, even if it is just a plain sore throat, they may have something else that is significant that they are unaware of and I have a legal, ethical responsibility to find that out as well as I can at the first visit.

Q. You mentioned hospital affiliations, is that an important factor?

A. Yes.

Q. What would be the importance of that?

A. I think patients want to know what hospitals a doctor uses. It also prevents problems when a patient
[7732] has been a patient for a while and then says, well, if I am going to have to go into the hospital for my diabetes, I want to be in Prince George's County Hospital and I say, gee, I don't go there. They said, I don't know that. Yes, it is in this booklet we gave you and sent to you when you first came in. So that kind of information obviates that kind of embarrassing and unpleasant situation.

Q. Do you have any information on billing or credit policy—not billing, credit policy reimbursements?

A. Yes.

Q. What would you tell your patients?

A. Tell patients if they have any trouble paying the bill, just let us know and we won't press them. The only thing we will press patients for billing is if we just don't hear. We will carry them indefinitely if they have trouble paying.

Q. Do you tell them whether you accept certain third-party payment mechanisms?

A. Yes, we do. We have a little business basically saying we accept all these third-party payments, but nonetheless, the bill is still yours. Don't tell me the insurance company only paid $7 and, therefore, that is all you are going to pay. It is still your bill because we don't have any way of knowing all the different
[7733] carriers and all the different policies that all the different carriers write.

Q. Are there any other elements in the brochure?

A. I ask people to criticize me. I don't know how sincere I am in that. I also say, if you have some nice things to say, I wouldl like to know about that.

I am putting in a new thing; we are having it reprinted. I am asking regular patients if it is convenient for them to pay at the time of the visit. I don't ask new patients because I don't want them to feel I don't trust them. People who have been coming back for a long time, if it is convenient, it saves a lot of administrative time and money if they pay at the time, but only if it is convenient.

MR. WRIGHT: No further questions, Your Honor.

JUDGE BARNES: Mr. Bierig?

Redirect Examination

By Mr. Bierig:

Q. Dr. Halberstam, have you ever been censored or otherwise reprimanded by a medical society for having the brochure that you have just described?

A. No.

May I add something? It is interesting about that, I haven't been reprimanded, in fact, the local medical society complimented me and they have helped to dis-
[7734] tribute the booklet to other physicians.

But there is another thing that I didn't get to earlier, which is that, again, in terms of medical society attitudes towards publicity, there was a time when any kind of public pronouncement by a physician was deemed unethical, where physicians nevear allowed their names to appear in print except in scientific journals and where the medical societies were very, very strict about what they considered advertising or self-aggrandizment by physicians.

In other words, an old Boston rule, the only time a woman's name should appear in a newspaper, three times, when she is born, when she has her debut—four times, when she marries and when she dies. That was really the medical society's feeling about that, too.

The people like Michael DeBaky and Denton Cooley and Jonas Salk, now Art Ulene and even M. J. Halberstam, who appear in public print with MD attached to them in the old days would have been censored by the medical societies for advertising.

That whole concept of keeping information away from the public or keeping controversy away from the public has totally disappeared.

I have never had a single bit of recrimination from a medical society, local or the AMA or any of the
[7735] specialty societies to which I belong on the basis of what I have written for mass circulation, magazines like "Life," or "The New York Times."

Q. How many such works have you written?

A. I won't say they are countless, but I have not counted them. Certainly over 100.

JUDGE BARNES: Dr. Neil Soloman in Maryland—

THE WITNESS: Exactly. Right.

MR. BIERIG: No further questions, Your Honor.

MR. WRIGHT: No further questions, Your Honor.

[5329] **Excepts of Transcript of Testimony of Franz J. Ingelfinger, M.D.**
Tr. 5329-5336, 5340-5342, 5345-5348, 5368-5369

Q. Before getting to the reasons on advertising, what sort of information, if any, do you believe can be disseminated, to enable them to make an informed choice of a physician?

A. I think I also indicated in this editorial, or in another one, that certain information, such as they were at the time publicized in certain directories were appropriate as long as it dealt with factual indisputable material and did not involve, and this is the crucial thing, did not involve the relative comparisons of value judgments or claims of superiority or of cheaper service. Also by saying: I am board certified in such and such and such. Yet, I think that it is perfectly proper to say what medical school you graduated from. It should be disseminated to the public. But anything
[5330] beyond that or any material that might appear factual but really isn't, such as fees, and we may discuss that later, that would I oppose.

Q. When you say that you would oppose this other advertising beyond the kind of directory type facts that you have outlined, could you describe very briefly in general terms the problems that you envision with the kind of advertising that goes beyond the directory type advertising?

A. You say very briefly?

Q. Well—

A. Two things, one, I think such advertising is very apt to be misleading even if it doesn't intend. Secondly,

you have already asked be about, which is the point of my editorial, namely, that advertising is apt to interfere with patient care. After all, the doctor's main purpose still despite his host of other duties, is to make the patient feel better.

Q. Take this question of misleading advertising first. Can you describe for the court generally why you believe advertising in the area of physicians' services may be misleading?

A. As I said, relative claims of superiority or of cheaper service and the like. The practice of medicine, as everybody always says, since time immemorial, is
[5331] both an art and a science. In the first place, no illness, as far as I know, can be predicted as to its outcome with complete assurance. No illness, not even a common cold. Let us take different categories of illness. Let us say a gall bladder operation, one can say it is performed by competent surgeons are 90 percent successful, on the average. But in the individual case, you might be among the 10 percent, where it isn't successful and perhaps even 1 percent who die from it. So, any claim as to success in gall bladder surgery would necessarily have to be qualified. One cannot guarantee a cure. One cannot guarantee success. I pick gall bladder surgery because that is one of the most successful. There are less successful.

Q. What about the area like heart disease?

A. More so, probabilities of treating, let us say, miocardia in fact, successfully so that the patient will not have another one. Perhaps 30 percent. Rheumatoid arthritis, there is no known cure for it at the present. There are a vast number of illnesses for which there is no known medical cure, and consequently, I believe, to make any claim that certainly a condition can be diagnosed and cured or alleviated is misleading because the patient may be in that percentage. The patient may not respond.

[5332] Q. What, if anything, can be termed as being misleading?

A. The last 25 patients, assuming the fact he has cured his last 25 patients, that is again, that implies a comparison. To say that he has cured the last 25, yes, but Dr. Jones' last three patients, died or didn't get well. Again, the statistics of medical medicine are very variable. It does not only depend only on the predictability of illness, but on the type of patient being treated.

Since I have been here, there was a meeting at MIT, where the Chief Surgeon General of the Massachusetts, the Chief Heart Surgeon and he were very much concerned about the mortality figures of certain bypass surgery. He doesn't want his mortality figures to be known to any other hospital because of the competitive factors involved. I don't blame him. But you see, what this means, is that the Massachusetts General Hospital, who has the most experience in our area, would have to turn down some of the more severe cases and the hospitals and units that treat those cases are going to have by nature the worse record, whereas the fellow who promises, the last 25 that succeeded, he may be operating on people, but they probably didn't even need the operation in the first place.

In such a hospital, the coronary bypass procedure,
[5333] the mortality rate is only three years. But the question is how many have they done, how severe are the cases and what kind of people are they dealing with? Are they rich patients who are well nourished, as opposed to drunkards? These make a tremendous difference when compiling statistics and in the outcome. Therefore, for a person to say that the last 25 patients came out or did well, means nothing.

Furthermore, the most obvious answer is left out and it is that the statistics of 25 means nothing because the next three may die.

We all know when working with the figures of the medical practice, you need hundreds of cases before you can make a pretty definite assertion unless you have a procedure, which was always fatal in the past, and then suddenly three people suddenly lived. Then you can make your claim.

But in general, to say that the antibiotic A is better than B, you need vast clinical trials and 25 patients are meaningless.

Q. What, if anything, would be misleading about a testimonial based on truthful facts?

A. As an anecdote, it isn't statistically valid. It happened to one person. I am sure in the great commotion now about Laetrile, somebody with cancer
[5334] probably got better. That is only one testimonial. That is not a true representation as a whole. By and large anecdotal reports are not considered to be scientifically very valid.

You will not find any articles in the *New England Journal* of a doctor describing a series of recent procedures of which he has had great success unless he has controls.

I mean, the same kind of patients treated at the same time but the only difference being that he didn't have that particular, they didn't have that particular procedure. Have I made that clear? No one person can predict anything.

The anecdotal reports mean nothing unless one has two groups of patients who are treated exactly the same way except that with the second group, the procedure said to be beneficial, wasn't given to the other control group.

Q. What kind of medical results can be predicted from one individual's experience?

A. None whatsoever. I am shocked you should ask that question.

Q. I am too.

You mentioned that you thought that comparative claims might be misleading I believe is what you said. What, if anything, is misleading about a claim, to
[5335] say that X is better than Y, or that so and so is the best doctor in town?

A. I don't know how you define best. Presumably he is the most successful healer. I put healer in general terms. It might be a surgeon or he might be something else. Again, how do you judge this. Only on the basis if his patients recover more rapidly and in a greater number, and less painfully, than the other patients of the other surgeons. I have just indicated the comparison of such a series with others, it doesn't mean anything because this Dr. X may be only taking the best possible subjects.

If I treat a lot of people for an illness that they barely don't have, then you are going to experience a high success rate. Some people believe that the best doctors are not necessarily the high success rate doctors but those who treat the patients with the greatest care and compassion. But after you have seen me, then you are relieved from your anxieties. Now, I might not be a good surgeon, but I might be a good doctor. Somebody calls me up, and asks who is the best surgeon, I can give you a number of names of who I think are good surgeons in the field.

Q. What, if anything, would be misleading about a physician holding himself or herself forth as possessing
[5336] a particular superior skill such as a new method of treating heart disease when the physician honestly believes that he possesses some form of new procedure or cure?

A. I think I have to make a sharp distinction now. If I may again go to gastroenterology, all right, gastroenterology, these days, is being affected by a technical procedure called endoscopy, which means putting tubes in all parts of the gut, really revolutionized gastroenterology.

We use flexible tubes, and the invention of flexible tubes of this type, has made development of all endoscopy, looking at the inside of the gut lining is now possible It is obvious, somebody who is well trained in that field, if he makes a statement that he has had one year's experience in endoscopy, I think that is a factual statement. But, if he compares himself with another endoscopy—well, this is where I say stop. How do you know you are better? He is better than I am because I am not trained in the field.

In other words, it is a development of the factual information that a person has a specialist training. If you have heart trouble, you don't go to a gastroenterologist.

• • • • •

[5340] Q. What problems, if any, do you see in the area of the advertising of fees?

A. Ideally, there shall be nothing wrong with fee advertising if the procedure involved was a constant specific process. But, again, we face the fact that most of the time what doctors do is not a constant and specific process but instead varies a great deal. Suppose I advertise history in physical examination $50.00, the physical history and physical examination, being the first two ingredients for a doctor establishing when seeing a new patient. Carrying out certain parts of the physical examination, amplifying later, the history and physical examination.

If a patient came to see me, this might occupy at least, an hour or hour and a half from the time I first saw the patient. Whereas. somebody else might do it in 10 minutes. Therefore, to advertise that you charge so much for a routine physical examination, which may be a slipshod and hurried examination of the patient, is not quite the same as a very thorough type of process.

Therefore, the quality and the nature of any item in the medical examination again varies so greatly is that I don't see how one can say my fee is cheaper than
[5341] the others. My quality may be cheaper than the others too. I may include less tests or I may include more tests.

You see, some physicians will include all of the tests, whereas others would not include the cost of the tests as part of the fee advertised.

As an example, one physician's examination can be exceedingly thorough or exceedingly sloppy. Do you know how much time, on the average, a physician spends in England with an old patient, and this was reported in the *British Medical Journal,* who sees an old patient, may spend from five to ten minutes in seeing this old patient. By old patient, I mean former patient. I don't mean old in terms of age.

Do you know how long the doctor takes, who works under the National Health Service, he spends anywhere from one to three minutes. Fees for such types of service mean nothing to me.

Q. What effect, if anything, does the advertising of fees have on the treatment that is rendered to a patient?

A. Another problem, of course, and I have been saying—I will make certain exceptions. I will undertake to do a blood study for glucose, let us say, for a

certain fee, and I think that is probably not misleading, and such a study would cost $10.00 to analyze for glucose. Maybe not with the correct answer, quality comes
[5342] into a certain degree. But, in addition, to go back to the doctor services, if I advertise that I will do a certain procedure, well, to diagnose treatment for a certain disease, I cannot predict just how much additional funds will be necessary because it may turn out that the case is pretty complicated.

I thought from what the patient said that he has an ulcer, but it really turns out that he has some heart disease. Therefore, what the patient thought he was going to have to pay in the beginning has now been changed due to complications or because of further tests that were done to confirm that his sickness is more serious than was first the case. So, the fact a doctor advertises his "starter fee" may be somewhat misleading for an ad because the patient thinks everything is covered. So, in the longrun, it might be necessary that it will cost another $100.00 to $250.00 that the patient didn't plan on paying. So, sometimes the doctor has to say: "I guess we can postpone it the time being." Hence, that doctor will probably be put in a corner for the sake of staying with the fee that he advertises.

* * * * *

[5345] Q. You mentioned earlier, Doctor, that you saw no problems advertising a $10.00 fee for a glucose tolerance test?

A. I just used a figure. Doing it for a blood level.

Q. What problems, if any, do you foresee holding forth a low and initially fee as sole fee in advertising?

A. I am not sure if I understand your question.

Q. Suppose a physician says: "I charge $10.00 for a glucose tolerance test." That is the only fee specified in the advertisement, what effect, or what problem, if any, might that cause from the point of view of the [5346] patient evaluating the amount of money that he expected to be paying to the physician?

A. I should think the patient would realize that this was not going to be the total fee by any means. As I see it, I have no great objection to that, but it tells the patient nothing about the interpretation of the test, whether it will have to be repeated because it was equivocal. Even tests are borderline. Taking the blood sugar level of a patient doesn't necessarily mean that he has diabetes at that age. We don't know. If it implies, of course, if the blood sugar level is abnormal, then an expensive and long deductive examination of his possible diabetes is in the offing. What was thought to be a $10 charge may lead to a $10,000 fee.

• • • • •

[5347] *By Mr. Bierig:*

Q. Can you briefly summarize the positions that you have taken on the position of advertising?

A. I thought at lunch that possibly I did not emphasize enough that my chief reason for being here is that I am interested in improving patient care and all customer protection, if you will, which is all part of improved patient care. That is the objective in mind, in trying to assess the impact of unrestrained physician advertising on the quality of patient care.

I cannot help but reach the conclusion that such advertising would be deleterious to consumer protection, and would be dilatorious to optimum patient care, and for this reason, I believe that advertising could be misleading, and to what extent it may be, would obviously be detrimental to patient care. That is point number one.

The second point, which was alluded to in my editorial, I believe, for reasons that I will later go into,
[5348] adequate patient care is still, to a large extent, based on the confidence a patient has in his physician.

To the extent that this confidence is eroded, eroded by commercial taint, the taint of advertising, to that extent, the physician's ability to help the patient, who acts as a healer, this is impaired.

These two points. Misleading advertising is an impairment of the physician's effectiveness which I see would develop as a result of unrestricted advertising and is something that concerns me.

I am here to pursuade this hearing that this is the case.

Cross Examination

[5368] *By Mr. Wright:*

Q. Yes, you were about to say?

A. Perhaps I had better amplify. I don't know of any course that anybody gives about advertising by doctors. You asked me if I had formal training in advertising.

Q. Did you have?

A. The answer is no, but I didn't realize that such training was even available. It is a new question that you are raising.

Q. Isn't it true that it is a tradition among physicians not to advertise?

A. It is a tradition among American physicians not to advertise, yes.

Q. With respect to your own opinion, isn't it true, that you have what you described to me as a gut feeling that it is not proper for a doctor to advertise?

A. Well, I have, let us say, that gut feeling in the sense, as I described my reaction when I first heard

about the FTC proposal, but I have I hope that I have substantiated that feeling with a variety of specific reasons today.

Q. With respect to advertising, isn't it true that you are not opposed with the advertising of basically factual information?

A. I think I have tried to define it twice now. The [5369] only problem is that sometimes it is going to be difficult for any one to decide what is factual and what is relative. But, I suppose, that has to be made in a variety of bureaucratic areas. One has to do the best one can.

Q. And with respect to that, to the factual information that you have talked about, both in the direct and cross-examination, isn't it true that you would have no feeling against the advertisement of that type of factual information, in radio, television and newspapers?

A. If done in a tasteful manner, and again, I think I mentioned to you the kind of credit line that is given by public broadcasting companies, where they say: "This ad was supported by a grant from the Honeywell Corporation." If the advertising were a black and white picture merely stating doctor so and so is a certified specialist, his office hours are so and so and residing at so and so, I think I would have no objection on TV. On the other hand, the man in a white coat, looking 10 times as nice as the doctor usually is, I would object.

JUDGE BARNES: Before and after pictures you would object?

THE WITNESS: Yes, because it is one case. Medicine is unpredictable.

Testimony of Robert H. Ebert, M.D.
Tr. 9308-9425

Direct Examination

[9308] *By Mr. Costilo:*

Q. For the record please state your full name?

A. Robert Higgins Ebert.

Q. What is your profession or occupation?

A. I am a physician and I am presently also the President of a foundation, Eleemosynary Foundation.

Q. What is its name?

A. Milbank Memorial Fund.

Q. What does the fund do?

A. It does several things. It publishes a quarterly called the *Milbank Quarterly* which is concerned with problems of health services and health services research and economics of medicine.

Secondly it provides grants to individuals or rather [9309] to people in universities that are working on things that are generally in the area of public health.

Q. How long have you held that position?

A. Since January 1st of this year.

Q. What did you do before that, Dr. Ebert?

A. Prior to that I had been Dean of Harvard Medical School from 1965 until June 30th, 1977, and then I continued on the faculty at Harvard for another six months working in the Kennedy School of Government.

Q. Can you briefly describe your education?

A. Yes. I received my Bachelor's degree at the University of Chicago, my M.D. degree from the University of Chicago and I received a Doctor of Philosophy degree in Pathology at Oxford University in England. Do you want me to go on with the other training that I have had or is that—

Q. Let me just interrupt you for a second. How did you come to being to Oxford?

A. I was a Rhodes Scholar and received a scholarship.

Q. Under whom did you study at Oxford?

A. With Lord Florey who was one of the people that developed, got the Nobel Prize for developing penicillin. This was before the war that I worked there.

Q. Where did you get your medical degree, Doctor?

A. From the University of Chicago.

[9310] Q. Did you serve in the military after that?

A. Yes, I was in the Navy after I finished my training in internal medicine and with the Fleet Marine Force in the South Pacific for two years.

Q. What did you do after you got out of the service?

A. I returned to the University of Chicago where I worked for ten years on the faculty. I did a great deal of clinical work during that time and became head of the Chest Unit at the University of Chicago.

Q. What position or rank did you hold?

A. I started out as an instructor and finally was made a professor going up through the various ranks of assistant professor and associate professor.

Q. Besides teaching at the University of Chicago did you engage in the practice of medicine?

A. Yes, the University of Chicago had a full time system of medicine so that all of the, everything that was done at the University of Chicago at the clinics' end, the hospital, was, all of the practice was by the full time physicians on the faculty and obviously part of this was related to the teaching of clinical medicine, but I worked actively in the clinic where we saw, I saw the average, an average of probably 40 patients a week and I also made rounds on the patients that were in the hospital, generally between 15 and 20 patients in

[9311] the hospital at any one time.

Q. Approximately when did you leave?

A. These were all private patients incidentally in the hospital.

Q. When did you leave Chicago?

A. I left in 1956.

Q. To go where?

A. I went from there to Cleveland to become the Head of Medicine at Case Western Reserve University and the Head of Medicine at the University Hospital in Cleveland.

Q. When you say "Head of Medicine," though, what did that title include as far as your duties and responsibilities?

A. I had the general responsibility for the conduct of the department, of the physicians in the department, responsibility for the student teaching and responsibility for the training of so-called house staff, that is the interns and residents that were assigned to medicine.

Q. Were there fee for service practitioners in the hospital?

A. Yes, a large part of the staff was called a volunteer staff and we were all fee for service. In addition, the full time physicians also practiced medicine on a fee for service basis and part of their income came [9312] from practice.

Q. How long were you in Cleveland?

A. For eight years.

A. I left then in 1964.

Q. While you were in Cleveland were you active in the local medical society?

A. Yes. I was a member of the Cleveland Academy of Medicine and was a member of Executive Committee for a number of years and was active in that, in the affairs there as an active participant in the Executive Committee.

Q. From Cleveland, where did you go?

A. From Cleveland I went to Boston to become the Head of Medicine at the Massachusetts General Hospital in 1964 and after one year I left that to become the Dean of the Medical School.

Q. When you came to Boston did you hold any professorship at any school?

A. Yes. When I came to Boston I was the Professor. I had been Professor of Medicine at Cleveland, rather at the University of, of Case Western Reserve. When I came to Boston I was the acting Jackson Professor of Clinical Medicine at Harvard.

Q. While at Harvard were you connected with any hospitals?

A. Yes, I was connected first of all with the Massa-
[9313] chusetts General Hospital. Subsequently as the Dean I was associated rather directly with all the hospitals because I was the President of so-called Harvard Medical Center which was a consortium of the major teaching hospitals at Harvard that included the Massachusetts General Hospital, Peter Brigham, Robert Bent Brigham, The Women's Hospital, Beth Israel and Children's Hospital and Massachusetts Eye and Ear Infirmary.

Q. When you were Chief of Medicine at Massachusetts General, what were your duties and responsibilities?

A. The duties and responsibilities were pretty much the same as they had been at Case Western. I had general responsibility for the overall staff, recommending appointments and promotions, supervising the house staff, teaching of medical students and general quality of care that was provided.

Q. Were there private fee for service practitioners working at the hospital?

A. Yes, a large number. A large number again of volunteer faculty as well as full time faculty but again most of the full time faculty also practiced on a fee for service basis.

Q. Can you briefly describe your duties and responsibilities while you were Dean of the Harvard

[9314] Medical School?

A. I had the general responsibility for the, first of all, for the fiscal affairs of the Harvard Medical School. Harvard is a rather decentralized university and each of the faculties or schools is pretty much responsible for its own budget and for its own fund raising and for its own conduct under the general supervision of the Harvard Corporation and Board of Overseers.

I was responsible generally for the curriculum, for the relationship with the teaching hospitals, for appointments, for all of the appointments and promotions, both term appointments and so-called appointments with a limited time, professional tenure appointments, for the conduct of student affairs, for the general relationship between the School of Medicine and other faculties and in addition I was both the Dean of the Medical School and the Dean of the Faculty of Medicine, which also included the Dental School. So I was generally responsible for the Dental School, too.

Q. Doctor, do you have any specialty?

A. Yes. I am a specialist in internal medicine and I qualified as a member of the Board of Internal Medicine.

Q. Besides the medical society in Cleveland which you mentioned, have you been a member of any other medical societies or associations?

[9315] A. Yes, I have been a member of the AMA. I have been a member of the Massachusetts Medical Society

and still am. I have been a member of various scientific associations and the Association of American Physicians and others that are related to internal medicine. I am a Master of the American College of Physicians and I was a member of the board, one of the people that gave the examination in internal medicine for a number of years, and set the standards for internal medicine.

Q. Have you held any positions such as board member or trustee or the like in any medical or educational related organizations other then the ones you have mentioned?

A. Well, I have been a board member. I was a board member of the Rockefeller Foundation for I guess from '65 until just January 1st. I was a member of the board of Milbank Memorial Fund and still am obviously but before I became President—I was a member of the board of Barnard College. I think those are the major ones.

Q. Have you ever held any position at the Harvard Community Health Plan?

A. Yes, I am the Chairman of the Board of the Harvard Health Plan.

Q. Did you ever serve on any presidentially appointed commissions?

A. Yes. I served on the Manpower Commission
[9316] appointed by President Johnson and that was the Medical Manpower, Physician Manpower, Health Manpower Commission and more recently I was a member and Vice Chairman of the President's Panel on Bio-Medical Research appointed by President Ford.

Q. Have you ever had any association with the National Library of Medicine?

A. Yes. I was also a member of the Board of Regents and, I mean Chairman of the Board of Regents of the National Library of Medicine.

Q. Dr. Ebert, what opinion, if any, do you have on whether or not physicians should be allowed to advertise?

MR. BIERIG: Objection, Your Honor. No foundation laid for this witness giving an opinion of this sort.

MR. COSTILO: Your Honor, Respondents called a number of doctors who have held positions of various sorts who they asked similar questions and asked opinions of who have had wide contacts in the medical community, not just academically but with fee for service practitioners, all of which this witness has had. He is eminently qualified to give opinions on the subject.

JUDGE BARNES: I think eminently qualified well states the case, I am willing.

[9317] MR. BIERIG: I would like to state the witnesses we called, all at least have been shown to have done work in the area of medical advertising or of regulations either by states or medical societies. I agree Dr. Ebert is eminently qualified. The question is "eminently qualified on what." I haven't heard anything in Dr. Ebert's background to suggest he is an expert in the field of advertising or in regulations by medical societies.

JUDGE BARNES: He is certainly more of an expert than I am and I maybe can use his testimony. I recall substantial testimony coming in in defense and I am very anxious to hear some other views. Dr. Ebert has been a teaching professional for some 25 years, Dean of some of the most prestigious medical schools in the country and I feel he is qualified to testify. If he has an opinion on advertising he may state it.

THE WITNESS: Thank you, Your Honor. In response to the question of "Do I think"—well, I can't remember the precise question. Perhaps you can reword it.

By Mr. Costilo:

Q. Surely. What opinion, if any, do you have on whether or not physicians should been allowed to advertise?

A. It is my opinion, Your Honor, physicians should be allowed to advertise. I say that because I think that
[9318] medicine has become increasingly complex in recent years. I think that patients often are not completely aware of the choices that are available to them and in part that is because their physicians traditionally have not advertised, there have been restrictions on advertising.

When I say "systems," what I mean by that is that it is no longer adequate to simply have a physician to take care of an individual or a family. One may have a primary care physician or a family physician but really what is needed is access to a whole system. You have to have someone who is first line, you have to be able to be referred to other physicians in the various specialties as necessary and you have to have access to perhaps not only one hospital that may not be totally equipped to do everything but perhaps a tertiary care hospital.

It is very hard, it seems to me, today for patients to know very much about how they get into that system. Obviously, one way is through advertising. When I say "Different systems," there are groups of physicians that provide a complete range of services on a fee for service basis and there are so-called medical foundations that do this on, to some extent, on a prepaid basis

and there are the so-called HMO's and these all have certain qualities about them and it seems to me that advertising would permit a far greater access to in-
[9319] formation of the general public so it is for that reason I state I am in favor of it.

Q. What is the present situation regarding the availability of information on which consumers can choose a doctor?

MR. BIERIG: Objection, Your Honor.

JUDGE BARNES: Can you give a foundation question first.

By Mr. Costilo:

Q. All right. Doctor, have you in the course of your experience, your various experiences, had the opportunity to observe what informational sources consumers have on which to choose a doctor?

A. Yes. I could also say that, you know, that there are various ways in which patients find physicians. Obviously they can call the local medical society and they can usually get a list of physicians. Some patients will identify a university or university hospital as a place that provides good care and will seek access to care there, knowing there is a university or a university hospital. There are various directories that have been put out in recent years that are available, although I think it is often difficult for patients to find them.

I suppose the most common way in which patients find doctors is literally by word of mouth. I suppose
[9320] when I was a Dean at Harvard and this still goes on, I got a telephone call from one or another persons either in the Boston area or more likely someplace else asking about referral to a physician, who I would

choose or who I would suggest. So that a lot of the information that is available today really almost comes from sort of, from one person to another rather than on a more orderly basis.

Q. In your opinion this is sufficient?

A. I don't think it is sufficient because I think it—well, often that kind of information is faulty as often is true of any kind of information and I think that basically what I am saying is I don't denigrate that information because I think it is good but I think it needs to be supplemented.

Q. Following up on your opinion you have just given on advertising, more specifically as to different forms of advertising, what opinion, if any, do you have about price advertising by physicians?

A. I personally think that price advertising is one of the things which the public is entitled to know.

In other words, I think it is often difficult for an individual to know what the cost of care is going to be. He knows a certain amount is covered by his insurance, possibly by Medicare or Medicaid, but he is not always sure what the additional costs are going to be.

[9321] I think that one of the reasons that this is true is that there has not been generally price advertising. I think it is reasonable again for the public to have access to information that tells them, you know, what do they have to put aside for this kind of care, what do they have to pay for a visit to a physician, a first visit or follow up visit and so on.

I think very often or quite honestly the cost of an operation, very often the patient is not aware of what Blue Shield will cover or Medicare will cover in the case of an elderly person and what the surgeon is going to charge over and above that and he often does

not find out until he gets the bill after surgery is done. And he has no point of comparison.

Q. What opinion do you have with respect to doctors and medical organizations advertising the services or their services and their facilities?

A. Well, again, it seems to me this comes back to the point I was making earlier, that it is very difficult for the general public to appreciate what is available in various kinds of systems.

For example, it is now mandatory, I guess, through recent legislation that there should be choice in any firm of over 25 if an HMO exists in a region, that there should be at least a freedom of choice between that and
[9322] an ordinary Blue Cross-Blue Shield or whatever commercial carriers may be offering. One of the great difficulties with this is it is not easy to get the best information about that choice. One gets some general descriptions of it but very often it is not considered proper to list the physicians, who they are and what their background is and so on. It does seem to me the kinds of things that can be put into advertising that lists the services, that lists the costs, that lists the people and their qualifications, is valuable in terms of educating the public.

Q. Doctor, what opinion do you hold, if you hold one, about whether or not physicians and medical organizations should be allowed to advertise facts relating to quality?

A. Well, it seems to me that, you know, quality is a very difficult thing to define, but one aspect of quality has to do with the general background and training of individuals and where they practiced and with whom. I think that one can make some judgments about qualifications, as to what quality is. I think, again, I have

to say this is one of the most debated points in medicine, as to how one makes a judgment about quality and whether PSRO's or anything else can do it.

There are some ways in which it can be done however. I think that one is reassured, if, for example, if a
[9323] hospital has a good pathologist and has a good review of tissues that are taken out at an operation and that the incidence of let's say normal tissues taken out is low. Furthermore, it does seem to me one can make some judgments on the basis of let's say mortality rates and morbidity rates. Let me give you an example of this.

There was a case in the Boston area of a hospital that was engaged, or a group was engaged in open heart surgery at this hospital and it turned out that their mortality rate was about 50 percent. In contrast to the mortality rate for the same procedures at let's say the Massachusetts General Hospital where the mortality rate was 3 to 4 percent.

The ordinary patient going to that hospital first of all probably would not have been aware of what the mortality rate was but he might well have known that quite a lot of patients died. And if it were possible to advertise that in this instance at a place where a large number is being done, that mortality rate is much lower, then I think as far as the public being informed in that fashion I would say I would rather make the choice of going to a hospital where the mortality rate is lower. This is true in a number of these kinds of procedures where there are enormous differences in mortality rates both for adults and children. So I think
[9324] there are areas in which one can, you know, and those are the extreme kinds of judgments about quality, whether somebody dies or lives but it is a pretty good or rather it is measurable one.

Q. What opinion, Doctor, do you have, if any, as to the form of media in which advertising might take place?

A. Well I wouldn't see any limit to it, whether it would be in newspaper, magazines, television, radio, whatever is the best way to get across to the general public. Because what I am really saying is I think that advertising is one form of public education.

Q. What opinion, if any, do you have as to whether solicitation of patients through means other than by advertising should be allowed?

MR. BIERIG: Objection, Your Honor. I think Mr. Costilo has to define what he means by soliciting of patients other than by advertising.

MR. COSTILO: Very well.

JUDGE BARNES: All right.

By Mr. Costilo:

Q. Doctor, when I ask this question about solicitation other than by means of advertising, I am talking about other contacts that physicians have in order to try to obtain business with the public or a prospective customer.

[9325] MR. BIERIG: Objection, Your Honor. The question is then going to be way too vague. We don't know what kind of other contacts are referred to. Mr. Costilo may be thinking of one kind of contact and the witness thinking of another and you may still be thinking of others.

JUDGE BARNES: Ask him if there are other forms of communication with prospective patients and what they are.

MR. COSTILO: Surely.

By Mr. Costilo:

Q. Other than by advertising, are you aware there are other forms of solicitation of business or possible solicitation of business by physicians?

A. Well I think there obviously are a number of different ways in which physicians can attempt to solicit professional business. Obviously, first of all, I might say facetiously that might be one of the reasons doctors often join clubs, country clubs, because it is a sense of soliciting—if you play golf with somebody or if you have a social affair you know that you are a physician and you have been able to say how or what your background is and what an excellent physician you are or if your wife says the same thing that is a form of solicitation I suppose and of course it is a form of—well, any kind of social gathering that is a form of solicitation.

[9326] In terms of how a physician gets started in a community, it is often a difficult one. Particularly a young surgeon who may be eminently qualified and if he is in a small community he may find himself in competition with some older surgeons that are, or who do the major part of surgery and yet he is not getting, or he may, as I say, be actually better trained and more competent. One way, one traditional way to solicit is to give papers to your colleagues, to be willing to give talks, to appear at staff rounds and in the various hospitals in the city. So that people are aware that you do have these skills that gives one an opportunity to present the cases that one has treated and then other physicians are familiar with the fact that that person is there, so they are soliciting, or in a sense physicians have to solicit to some degree both from their colleagues, if they are largely doing a referral service.

and socially by being known in the community or in a church or whatever.

Q. Do you have any opinion on whether or not, for example, a doctor, say in industrial medicine, should be allowed to directly to his potential patient class, industrial corporations, or what have you, purchasers, to solicit business?

MR. BIERIG: Objection, Your Honor. You get into
[9327] specific things. You can list a whole slew of specific examples. I am not sure Dr. Ebert has been qualified as an expert in industrial medicine and knows all of the ramifications of industrial medicine. I think if Mr. Costilo wants to ask a general question about advertising that is one thing but when we get to specific problems unless Dr. Ebert can be specifically qualified as an expert in this field I think we are going a little too far.

JUDGE BARNES: We are not talking about whether or not he is qualified in industrial medicine but whether or not he has an opinion on solicitation and this is solicitation and I already ruled he can testify in this area so you may answer, Doctor.

THE WITNESS: Thank you, Your Honor. It seems to me that an individual who has trained let's say not only in medicine but in let's say in public health as well, and has the expertise that can be offered to an industry, either large or small but more likely small because the larger one is more likely to have professional help, I would say that that would be performing a service, because there are very serious questions in industrial medicine. It is very difficult, unless companies are willing, or can find the appropriate help, to monitor the plants' plans.

While I am not an expert in industrial medicine, I
[9328] have had occasion to be involved in two rather substantial episodes and one was at the University of Chicago in which during the war, working on the Manhattan Project they used beryllium and a number of patients developed so-called beryllium disease of the lung. There were some very serious questions then about what protections there were and who was supervising and so on.

The second was with Cudahy which manufactured Old Dutch Cleanser which contains silicon. There were, or we happened to go through about 50 patients to review their cases but, again, it was after the fact. Clearly, if they had had access to somebody who was expert in industrial medicine, much of that could have been prevented. I would say particularly in the area of industrial medicine, because after all what one is seeking is really prevention, that any one can solicit appropriate services would be good in the public interest.

By Mr. Costilo:

Q. Dr. Ebert, do you have any opinion as to whether or not the private practice of medicine is a business?

MR. BIERIG: Objection, Your Honor. I don't know whether I have to state the grounds for the objection except to say that whether Dr. Ebert believes something is a business, however undefined that term is would seem to be totally irrelevant. It also has no
[9329] significance to the case. The question is meaningless.

MR. COSTILO: Your Honor, it has a lot of significance in view of testimony given by Respondents' witnesses who spoke about professionalism and spoke about the fact that advertising would commercialize

the medical profession and that patients would think of their doctors as businessmen and I think that it directly relates to the opinion evidence given by a number of doctors who testified for Respondents.

JUDGE BARNES: I think you can rephrase your question without coming out with a flat question of the business and this is something I will have to decide and I am sure there are court cases and I don't see how this is a real problem in the case. You might ask if advertising would detract from the professionalism of doctors. Whether or not it is a business is really not a question.

MR. COSTILO: I will rephrase the question.

JUDGE BARNES: Income for producing a service, that is for certain.

By Mr. Costilo:

Q. Doctor, do you think that advertising will detract from the professionalism status of physicians?

A. No.

[9330] MR. BIERIG: Objection again, Your Honor, I don't think there is foundation laid for this question.

JUDGE BARNES: I think it is in the general area that I have been permitting questions on so I will permit that question.

JUDGE BARNES: Do you have more comments, I am sure he had more comments.

THE WITNESS: Yes. I think the question of advertising detracting from the kind of the professional image of the physician or the professional view of physician, is—I answered "No" because I think that the nature of professionalism is a kind of complicated

one and perhaps should not be everything, or everything about it should not be lumped together. Let me be specific.

Part of professionalism and a part of what happens to a physician as he becomes professionalized first in medical school but much more as he goes into the clinic and in his training as an intern and resident and fellow, is that he is imbued with a general feeling and I think most physicians are, that, A, the welfare of the patient comes ahead of everything else, including his own comfort and his own family. That means he can be called in at any time of the day or night. That may be sometimes exercised in breach more but nevertheless it is the general kind of professional ethic of the physician. And a rather deeply ingrained one.

[9331] I think that in general, my view is probably a pretty good one, that there is that kind of feeling about the welfare of patients and that is the primary role of physicians. There is another side to professionalism, though, that I would relate much more to what I would call a kind of "guild" philosophy may or may not be that effective and the "guild" philosophy is a little more restrictive. It comes really out of the English guild. As a matter of fact medicine was organized in guilds in Great Britain and they were not kind of adapted to the environment here during the colonial times because really there was not—as someone pointed out there was not enough money to pay physicians that belonged to the guilds that were surgeons or apothecaries so there was a kind of very free and easy kind of approach to medicine in this country, particularly up through the 18th and 19th century.

But then gradually, with professional societies, not exclusively AMA, but other specialty societies, The

American College of Physicians, Surgeons, Opthalmologists and the like, some of this guild philosophy was reintroduced into medicine in the country and that guild philosophy to a degree is anti competitive. Guilds say: You abide by our rules but we will set the rules and it is not the marketplace philosophy. In fact it
[9332] probably precedes Adam Smith.

I think a good deal of economic thinking of physicians is that kind of almost mercantile thinking of control. So I think advertising would open that up, would make it more competitive, which in my view is not a bad thing, particularly now since one is talking very often about systems without in my view injuring what I think is the more basic part of professionalism which is caring about the patient which is really quite different and it is not necessarily from the guild at all.

Q. Doctor, are you generally familiar with the relief that Complaint Counsel is seeking in this case?

A. Yes.

Q. And specifically in regard to the role, if any, that the medical society should have in regulating advertising?

A. Yes. I don't think the medical society is the appropriate vehicle for regulating advertising. I say that because, again, I worry about this kind of guild philosophy, that it is too easy in a sense to use that in a way, and sometimes even inadvertently, as a weapon against anything new, any novel approach to the practice of medicine. Although there is ample evidence that has been true in medicine but there is opposition to anything new that is introduced. If advertising is controlled then by the medical society it does seem to me
[9333] it opens up that avenue and I think there are other ways of regulating them.

Q. Can you amplify any further with respect to your thoughts on this subject?

A. You mean in terms of the regulations?

Q. Yes.

A. Well, Your Honor, my feeling about advertising by physicians, is as follows, that the two major controls against let's say false advertising would come, one, from sort of the basic ethical feeling that physicians have, which I believe is there and which I think is very strong and I think the majority of physicians have that and would not under any circumstances wish to advertise falsely but only to state what it is they do and what they have to offer or what the system has to offer.

Secondly, I think that the threat of malpractice would be an enormous deterrent to false advertising by physicians who want to remain as active parts of the respected community. In other words, if they make false claims, false claims are made by individuals or by groups, I would think that would have a fairly potent effect in a court of law if that was not, or if what was claimed was not accomplished. In fact something rather bad was accomplished. So I look upon those as the two kinds of major deterrents in this.

[9334] I would also say that it seems to me if I can expand a little bit further, Your Honor, on this?

JUDGE BARNES: Yes.

THE WITNESS: It does seem to me that one has to look at the whole question of advertising by physicians kind of in the context of the times and of why it may be important at one time and not at another. If one looks at medicine in this country in the 19th century it was dominated, it was dominated and the

medical practice was dominated by the proprietary medical schools and most of graduates were from such a school and there were something like 480 medical schools that were opened between 1815 and about 1900.

Of those about 150 survived. But they were proprietary schools. They had very low standards. And the graduates were clearly not very capable and there was, without any question, great concern on the part of more legitimate practitioners about the control of what were viewed as relatively fringe people and quacks.

There was—and that was real in the 19th century. Following activity of the AMA in 1904 with the creation of a council on medical education and more importantly the report by the Carnegie Foundation, the report by Abraham Flexter in 1910, there was a great reform in American medical education and the number
[9335] of schools was reduced to 80 and the number of graduates was cut in half and those that subsequently graduated I would say went through a very fine filter in terms of their previous education, of their qualifications, of their character and so on.

So that the situation today is totally different than it was let's say 75 or 80 years ago. Seventy-five or 80 years ago there were relatively large numbers of physicians who one would worry about making false claims. I think that that number today would be very small. I have a very great faith that the physicians being turned out today are really of exceptionally high quality and quite uniformly high.

What is really impressive in this country is it is not just one or two or ten medical schools that are well qualified but I would say the majority are and the people who come out I think are remarkably well trained. So when one is looking at the issue of what

one is trying to regulate by controlling advertising it seems to me that you, that one is using a code that basically was developed at another time around another problem. Today the problem is more what more information can patients get and what can they learn about what is available in their community in a much more complex time. So those are the kinds of general things I would state about that.

[9336] Q. Do you think that the AMA and medical societies should police incompetent doctors through the device of advertising restrictions?

MR. BIERIG: Objection, Your Honor. The question has several parts to it. It assumes facts that are not in evidence and it is not until now been an issue in the case as to whether the AMA should police incompetent doctors through control of advertising.

MR. COSTILO: He is not a witness. Facts are in evidence that can be determined and if not he is permitted to answer a hypothetical and it is a fundamental issue as to whether or not advertising should be used as an indirect device to try to get at another problem of competency. I think that insofar as the fact that it has a couple of components I think the witness can understand and should be permitted to answer.

JUDGE BARNES: I think the record does contain evidence at the present time about incompetent doctors. It seems to me we took a trip out to California and heard testimony from several plastic surgeons and the testimony demonstrated they were clearly incompetent and were advertising so it is on a record basis "Should the medical society police incompetent doctors by means of controlling advertising." I think that is a legitimate question.

[9337] MR. BIERIG: If I do say so, I think it is the ultimate issue in the case to be decided not on the basis of Dr. Ebert's speculation.

JUDGE BARNES: That is correct, but I seem to recall experts are permitted to testify on the ultimate question. It does not mean it will be accepted. It is his opinion and I will use my own but his opinion might be helpful to me.

THE WITNESS: Thank you, Your Honor. My own feeling is that attempting to control the fringe practitioner, the individual who is doing the kind of cosmetic surgery that you referred to or other kinds of things which are on the fringe of what is legitimate in medicine, that attempting to do it by controlling advertising is rather indirect and that what really—well, I would almost say since usually the people are outside of legitimate medicine and practice outside of the medical society and they don't belong and many of them are moving from one state to another ahead of the law, I would say that how they should be regulated is much more in the substance of what they do.

There are laws that govern where surgery can be done. There are laws which govern the kinds of things that are necessary within the hospital, that the hospital must have in order to do surgery. There are laws that
[9338] require certain kinds of supervision of let's say tissue committees and so on at hospitals by regulations.

And it would seem to me that the medical society, in its concern, which is a legitimate concern for the welfare of the legitimate public, would be much more advised to go immediately where this practice is being carried out to see whether there is not a way of controlling it quite directly, because usually there is. I would have said quite honestly that the advertising

by these fringe people might also be an advantage in the sense that it gives you evidence that it is going on. I wouldn't be worried, I would be almost more worried if it was all underground and there was no way to know that his kind of thing was being kind of promulgated by word of mouth.

So I really think that one can clearly attempt to control, you are never going to control completely this sort of thing but one can follow up on it and do it rapidly enough so it simply makes it very uncomfortable for people to do that kind of practice or anything illegal.

Q. You mentioned that with respect to them being fringe practitioners, outside, I don't know if I use the exact words, outside of organized medicine or something equivalent to that, what is the significance of that
[9339] fact if it is a fact?

MR. BIERIG: Objection, what is the significance of the fact if it is a fact? Again it is undefined terms like "Fringe practitioners." The questions are all vague and these kinds of questions are not proper.

JUDGE BARNES: Can you rephrase the question.

By Mr. Costilo:

Q. Surely. With respect to the statement that you made about practitioners being outside of organized medicine, can you explain what you meant by that?

A. Your Honor, what I meant by that statement was that organized medicine clearly has an influence over those people who belong to the medical societies and who can be brought before the medical society and reprimanded by the medical society, but if a physician does not belong and does not care whether he belongs or not, and that is not essential to what he is doing,

then it seems to me that the medical society can do very little about that advertising because it is not under the control of that particular, or that particular aspect is not under control of the medical society.

JUDGE BARNES: The issue here is whether to take all control away from the medical society as to advertising?

[9340] THE WITNESS: Yes.

JUDGE BARNES: That is the basic issue and I think that is what Mr. Costilo is seeking an answer to. The question is do you support that view?

THE WITNESS: Yes, I do. I support the view not to take away overall advertising because I think it now is ineffective in controlling a group of physicians who are operating outside of the framework of organized medicine anyway and it is limiting the information that can be given to the public by perfectly legitimate groups of physicians, therefore I do think the relief sought is proper and it should be taken away.

MR. COSTILO: Your Honor, the next phase of the questioning of Dr. Ebert is going to go into the various justification, medical type justifications that have been offered through testimony during the defense and I just wanted to give you a preface as to where we are going right now.

Dr. Ebert, there has been testimony during the hearings to the effect that if the AMA and medical societies are not permitted to regulate advertising there will be great dangers from quacks advertising? To some extent I think you covered it in your testimony but I would like you to address the specific testimony points one by one. What opinion, if any, do you have on that

[9341] subject?

A. Well, as I say I think quacks are going to be advertising outside of the framework of organized medicine and therefore I would think that they may or local medical societies would have no control over it, unfortunately, but that is true.

Q. There also has been testimony, Dr. Ebert, to the effect that the public is not capable of differentiating between advertising of the background and qualifications of different physicians and do you have any opinion on that subject?

A. Yes, I do. I have the opinion that we, and I mean by "We", most professional groups and most groups with special knowledge, underestimate the ability of the general public to discriminate. I think the general public is considerably wiser than we give them credit for. I think the view of the general public that they would be unable to discriminate between let's say the ad of a quack that says he can grow back all of your hair in two weeks versus advertising of a group of physicians where clearly they are legitimate practicing physicians is to say that our public is totally uneducated and totally unable to tell the difference between what is appropriate and inappropriate. I don't think that is true. I think we have a pretty well-
[9342] informed public that has been battered with all sorts of advertising and I think they are able to discriminate. At least that is my view.

MR. BIERIG: Your Honor, I would just like to interject since Mr. Costilo makes reference it is very ironic for the Commission which argues for the ignorant consumer, the gullible, tons of cases that the FTC argues for that standard now sponsors a witness that tells us how discriminately the public is said—

JUDGE BARNES: Mr. Bierig, that remark has gone unsaid. Put it in your brief. I know what the Commission has said about gullible and the incredulous and I am well aware of those cases.

Proceed, Mr. Costilo.

By Mr. Costilo:

Q. There also has been testimony, Dr. Ebert, to the effect that advertising of exaggerated claims by some doctors will induce other doctors to do the same thing in order to compete and what is your opinion on that point?

A. First of all, I think that this goes back to some comments I made earlier, Your Honor, in which I felt in general that the well trained physician is not going to make exaggerated claims because he has a kind of ethical code that has been built up all through his professional training.

[9343] Secondly, I think he is not going to make exaggerated claims for the reason I also mentioned about malpractice, that it would be controlling, and, thirdly I would also have to say that many physicians, most who are established, simply don't need to make exaggerated claims in order to have a reasonable practice. There is no advantage to them. The complaint of many physicians is that they are too busy, it is not that they are not busy enough. So the idea that one group making an exaggerated claim is going to lead to others, I simply don't believe.

Q. There also has been testimony, Doctor, to the effect that advertising by doctors will interfere with the high degree of confidence and trust that the public now holds their doctors in and that this will interfere with the doctor-patient relationship and in the treatment of patients. Do you have an opinion on that point?

A. Yes. Again, I think first of all the doctor-patient relationship is a complex one and one that is an important one. It includes such things as the so-called placebo effect of medication, which simply means that even though a medicine may not be, or a treatment may not be specific it may have the effect of making the patient feel better at least, because of that kind of--well, it is very difficult to define the relationship of the kind of authority figure that says this is not going to work.

[9344] I might add that this kind of placebo effect can be obtained a lot of different ways including faith healers and witch doctors. But nevertheless it is something that probably is important in the practice of medicine, trust and confidence. I would say something, I would make the observation that American medicine, as a group, and organized medicine, such as AMA, indeed academic medicine, has not received what I would call the most favorable press over the last decade or two.

Indeed, it is hard to pick up a newspaper, a magazine, or watch a television program that does not in one way or another bear out an attack on the profession. What is terribly interesting is that in spite of this and in spite of the fact this is another kind of I would say a form of communicating with the general public, which is not, which isn't the same as advertising but it is a form of communication, does not appear to have influenced at all the attitude of patients toward their individual physicians.

A survey was recently published and I can't remember offhand who wrote it but it was published by the Johnson Foundation, Robert Wood Johnson Foundation, of preferred attitudes about how the people looked at physicians as the general thing where they had some question about them as a group. But where the attitude

[9345] toward the individual physician, the patient's own

physician, was still very high. So I would say, I don't see based on that kind of evidence that the fact that physicians advertise would have an impact on how patients look to physicians and how well they trust them and how effective physicians can be.

JUDGE BARNES: Doctor, are there courses on medical ethics given in medical school?

THE WITNESS: Yes. There are beginning to be. It is terribly interesting, really, because the kinds of issues that have come up more recently in medical ethics, in a curious kind of way have almost nothing to do with these issues. They have to do with really some quite profound issues, the issues of when is it legitimate to stop the use of a lot of technology in preserving life. As you know, there was a redefinition of death, "Brain death," and these are quite profound ethical issues.

If one can anticipate that there will be, for example, and this now can be done, that one can anticipate that there will be defects at birth, is it ethical to interrupt that pregnancy?

These are the kinds of ethical issues that now are being discussed and a part of that also is this broad question of "What is the relationship of the doctor to the patient?"

Is this sort of authoritarian figures concept—is that
[9346] the best?

Does the patient have certain kinds of rights?

Does the patient have the right to know?

Does the patient have a right of access to his chart?

These are the kinds of issues that now are being discussed and being debated. Most medical schools today do have courses in these.

But as I say, it is interesting, there is almost a complete dichotomy between that and I would say the

almost formal code of ethics put out by organized medicine.

By Mr. Costilo:

Q. On the same point about patient confidence in his or her doctor, the point or subpoint had been advanced in testimony that a patient would be less likely to follow a doctor's orders on medication if there is widespread advertising. Can you comment on that?

A. First of all, again this is something, Your Honor, which there is good deal of interest in. It is called patient compliance which basically means one of things that influences a patient to follow his orders or not. What things?

It is clearly a situation that no one fully understands in full detail. But it is also clear that there are certain things that influence the patient. One is the amount of
[9347] time that the physician spends in explaining what it is he expects the patient to do. If it is hurried, if it is done quickly, often the compliance is low.

It further is related to the care with which the physician follows up to see if the patient is taking the appropriate medication.

There are some interesting studies on this to indicate that the facts other than whether it is a physician giving the advice or someone else, which is more effective?

For example, there was a study that was done at the University Medical Center in Memphis, a study of diabetics where clearly the compliance was enormously important. One could not only measure compliance by how the patient felt generally but how often he had to be admitted to the hospital with the case of diabetes. One went with the regular physicians and were advised by them and the other group went to a group of speci-

ally trained nurses who spent much more time with the patients and explained much more what should be done and it was that group that did far better.

So compliance is not something that is simply based alone on a doctor-patient relationship but it is a much more complicated question. I would just add one further
[9348] complication. It clearly is related to the emotional status of the patient. Very often a patient may be depressed and feel it is just not worth taking anything or indeed it could almost be suicidal. It is a kind of, "not to comply" is a sort of almost a suicide wish and that is not uncommon in medicine.

Sir, the skill that I would say here a physician has is don't find some of these kinds of things but that is a long way around of saying that I do not think that advertising by physicians is going to necessarily affect the compliance of a patient in taking medication.

JUDGE BARNES: Let's take a five-minute recess.

(Whereupon, a brief recess was taken.)

JUDGE BARNES: Are you ready?

By Mr. Costilo:

Q. Yes, Your Honor. Continuing along the same line we have been going into, there has been testimony also, Dr. Ebert, to the effect that advertising induces patients to undergo medical treatment they do not need and this would lead to overutilization of medical services. What opinion, if any, do you have on this point?

A. Well, I think there are two aspects to this. One has to do with the patient with a chronic illness or coming into a physician, a non-surgical physician.
[9349] Obviously advertising may influence the first visit, but by and large after the first visit the number of

visits that the patient makes is pretty much dictated by the physician himself unless moré complication comes up where the individual has to seek additional help.

In other words, it is usually the physician that says when you should return and not the patient. So I don't think advertising necessarily would increase that kind of utilization. One could obviously make the case about surgery and indeed as I am sure you are aware there is concern today about unnecessary surgery and obviously the worry would be "Does advertising increase that likelihood?"

First of all, I think that the control of unnecessary surgery has to come about in other kinds of ways. It has to come about by more stringent review of tissue committees in hospitals that normal tissue is not taken out.

Secondly, that medical societies should perhaps be more vigorous than they are now in bringing to the attention of their own internal committee the cases in which clearly the practice borders on malpractice because of the amount of unnecessary surgery that has been done. Usually that is known in the framework of a hospital.

Thirdly, a number of insurance companies today are
[9350] advertising that they will give a second surgical opinion free. In other words, they pay for a second opinion about surgery just to determine whether or not it is necessary. It is very hard to say whether advertising would increase let's say the utilization of the physicians and in particular surgery. I think I could make the case that it could even do the opposite, because I could make the case that with appropriate advertising of a group that their record was better

than the others in terms of doing only what was necessary—it couldn't, or in my view it can influence things in the opposite direction. In other words, I do not think advertising per se is going to increase utilization. There are many other factors.

Q. There is also testimony to the effect that if price advertising is allowed the public will be unduly influenced by the prices advertised by doctors rather than the quality of care offered by physicians. Can you give an opinion if you have one on that point?

A. First of all, I think one should remember that a substantial part of the public is insured and therefore the sort of basic cost is not borne by the individual patient either through federal insurance or Blue Cross-Blue Shield or commercial carriers so what one is talking about very often is the increment, what over

[9351] and above insurance is going to cost.

I don't think in that range that, first of all, the patient is going to be unduly influenced by price because it is not—or that price does not make that much difference in the budget.

Secondly, I think that, frankly, I think the patient should know what the price is, particularly if the price of a surgical procedure which is over and above what may be covered by insurance is involved.

Q. There has also been testimony to the effect that if a doctor advertises a set price for a given treatment and then determines on examining the patient that more work is required to treat the patient, that the doctor may cut corners in order to meet the price that he had originally advertised. Would you give your opinion on that point?

A. I think I can answer that, I think, it seems to me best by simply saying that one way, if you like, in which a price is set, is in HMO's, which are prepaid.

Obviously the money that comes in on a computation basis pays for all of the care. So if one were to make the case that somehow or other if more had to be done that corners would be cut. I think one would find it evident there. Now a considerable amount has been done in reviewing the experience of HMO's, particularly with the long history of Kaiser Permanente which is
[9352] very large, HIP in New York and some of the others. There is not any evidence that corners are cut in treatment or in diagnosis.

Secondly, it seems to me with the individual physician, let's say if he advertises a set price and finds it takes more time, that to some extent that would be done without, because with other patients he may spend less time, in other words, it is a little bit of an insurance principle that it will take more for one than another so the price comes out sort of as an appropriate one so he would set it with that in mind. It is hard for me to think a physician will do less than what he thinks is appropriate because he set one price and it would take him longer than he thought.

Furthermore, it would seem to me if something came out, let's say of a routine physical examination with a set price, and which identified a significant illness, that could be explained to the patient that this goes beyond what the price was that was set for the physical examination and would talk quite openly with the patient about what additional costs there would be. So I don't, or I really don't feel that that that argument would hold.

Q. There has also been testimony to the effect that advertising of prices for certain medical procedures such as physical examinations might be misleading to
[9353] the public in that consumers would not be able to compare prices between doctors since one doctor might

spend more time on a patient during a physical or give more tests than another. What is your opinion on that point?

A. Well, let me make a general observation about, first of all, about this point. I think that in general any patient that simply goes in for a routine physical without any other notion of going back to that physician or getting involved in some general care system is wasting his money anyway, frankly. So that I think that it is simply inappropriate to go for a routine physical examination unless it is your plan to return to that physician or system.

First of all, that is the baseline. There is not any very good evidence that one picks up very much in routine physical examinations. So that I think it is an inappropriate use of physicians to do that just for the physical.

Further, it would seem to me that if a physical examination is advertised as a part of the services provided with a physician, by a physician, that there would be ultimately some pressure for a consumer, from consumers groups and others to say precisely what was done if that becomes a question of one price being set too low because most of it was done either in
[9354] a questionnaire in a fashion that didn't use much of the physician's time so I think there are other ways of controlling that. But as I say my fundamental objection is really, and this can come out, and this is why I come back to what I think is the basic, in my view the basic point I have tried to make, Your Honor, that is, the reason that I think that advertising has become important is because it allows one to advertise different systems and to say: These are the array of things that we can offer to you.

And that is just not available today.

Q. You mentioned consumer directories, I believe, earlier in your testimony. In your opinion, are these adequate to satisfy the information on the needs of the public?

A. Obviously they are very good in quality and what is put in the directories, what is available in terms of cost, available on what the charges are and the backgrounds of individual physicians, what they are trained in and what they limit their practice to if they limit it, I think it is a good step, that there ought to be more directories and I would certainly want to see an increasing use of such directories.

I think that anything that gives the public greater access to information and useful information is im-
[9355] portant and the directories of that sort, as I say—if they are well done and kept up to date they are very helpful. One of the problems with them is too often the patients don't know they are available. In a sense what they need to be is advertised that they are available.

Q. All right. I think I am pretty much finished with the areas I wished to cover but I would like to check my notes, Your Honor. Dr. Ebert, I think you may have covered this in part before or in full before but I want to go back for a moment to the fact that there was testimony during Respondents' case that some incompetent physicians outside of organized medicine attract some of their patients through advertising or maybe more than than some of their patients through advertising. Do you have an opinion on what effect allowing other physicians to advertise will have on the ability of the incompetent physicians to attract patients and/or possibly harm them?

MR. BIERIG: Objection, Your Honor. This is totally speculative. This goes beyond even the speculation we have had so far.

MR. COSTILO: I think it relates to the doctor's testimony as to his opinion as to the role of advertising. What are the positive effects of advertising? Which he is testifying about here. And in relationship to the [9356] justifications being offered by the defense witnesses that there will be these incompetents who are advertising. I think there is a direct relationship and that the doctor should be permitted to answer the question.

JUDGE BARNES: Let's have the question read back. I think it is a little confusing.

(The record was read by the reporter.)

MR. COSTILO: I degree it is confusing and I will try to simplify it.

By Mr. Costilo:

Q. What effect, if any, would allowing legitimate physicians and practitioners to advertise have on the so-called fringe practitioners who advertise?

MR. BIERIG: Objection. It is the same question. It is not any clearer. The problem is it assumes a fact, namely, that legitimate physicians would advertise if permitted to do so without any basis for that leap in logic and it is calling for speculation based on a speculative event.

JUDGE BARNES: I think we have to assume this would be a useless proceeding in the event that advertising is permitted and no advertising ever occurs—I think you have to assume that advertising would occur if Mr. Costilo got his relief.

In fact, I have seen some advertisements from
[9357] doctors just very recently. I was down in North Carolina on vacation last week and bought the *Raleigh News Observer* and each day I bought the *News Observer* there was an advertisement in the newspaper by three physicians announcing the association with a firm of another physician and their types and extent of practices and specialties so there is physician advertising.

MR. BIERIG: There always has been, I think, the evidence reveals but the problem is we can't speculate on what kind of advertising there will be, who will advertise, what areas of practices and what geographic areas of practice so Dr. Ebert is speculating based on unstated speculations. To speculate in general is one thing but to speculate on the basis of unarticulated other speculations is really going beyond anything that is proper under the Rules of Evidence as I understand it.

JUDGE BARNES: I will overrule your objection and ask you to assume, Doctor, there is advertising by legitimate physicians and what effect, if any, would this have on the so-called fringe doctors who have been advertising?

THE WITNESS: Well, I would think it may have several effects. One effect is that I think it perhaps would, it might actually dilute out some of advertising
[9358] by the fringes, plural, because there would be available to the public advertising by legitimate physicians and knowledge that these services were available and perfectly legitimate groups or individuals. So I think it could, in that sense, have a favorable effect.

I don't think there would be, or I can't imagine why it would necessarily increase the amount of advertising

by the physician, the fringe individual, the fringe physician, who is practicing poor medicine and doing things which would not be considered warranted by a majority of the profession.

Finally, I come back to a point that I made earlier, that is, that, A, it gives the public the ability to see advertising by one group and another. It makes some judgments as to the qualifications of the individual physicians or groups of physicians.

Secondly, it does seem to me that the fact that these physicians who are advertising falsely gives the legitimate regulatory agencies an opportunity to see what they are actually doing, not to regulate the advertising but to regulate the practice, which is really the final payoff.

Q. Doctor, what opinion, if any, do you have as to the role of competition with respect to the private practice of medicine?

[9359] MR. BIERIG: Objection, Your Honor.

JUDGE BARNES: I think you have about finished your examination of this.

MR. COSTILO: I said I wanted to have a wrapup, Your Honor.

JUDGE BARNES: You always do.

MR. COSTILO: Let me just check with my colleagues.

JUDGE BARNES: Sometimes you get into trouble when you go into wrapup and you are better off to leave the record where it is.

MR. COSTILO: No further questions, Your Honor.

JUDGE BARNES: Are you ready to cross examine?

MR. BIERIG: May we have about 10 minutes, Your Honor?

JUDGE BARNES: All right.

(Whereupon, a brief recess was taken.)

JUDGE BARNES: Proceed.

Cross-Examination

By Mr. Bierig:

Q. Dr. Ebert, when you were associated with the Harvard Medical School you were employed on a salaried basis; is that correct?

A. That is correct.

Q. Were you a member of the Massachusetts Medi-
[9360] cal Society at that time?

A. Yes.

Q. Were you a member of the American Medical Association?

A. I honestly can't remember during that period. I was at one time and then not another and I rejoined. I don't honestly recall.

Q. Did the Massachusetts Medical Society or American Medical Association ever declare it unethical for you to be employed on a salaried basis at the Harvard Medical School?

A. No.

Q. And you stated you are currently a member of Massachusetts Medical Society, I believe.

A. As a non-resident member.

Q. You are currently a member of the American Medical Association?

A. No.

Q. Have you throughout your career been a member of the AMA?

A. No, as I indicated, off and on.

Q. Isn't it true the reason you are not a member of the American Medical Association is that you believe you were not getting sufficient benefits from membership to compensate you for the dues you were paying?

[9361] A. Correct.

Q. Do you recall whether you were a member of the AMA in June of 1976?

A. I was not.

Q. And although you were not a member you published an article in a magazine called *Impact*; is that correct?

A. Is that the—I can't immediately identify the magazine. Tell me about what the article was?

A. It is entitled "New Technology, How Far and How Fast"—

A. Yes.

Q. And *Impact* was a publication of the American Medical Association?

A. Yes.

Q. And you authored the article?

A. Yes.

Q. Did you write the article in order to enhance the economic welfare of AMA members?

A. No.

Q. Did you write this article in order to enhance the economic welfare of physicians generally?

A. No.

Q. Do you believe that *Impact* published the article in order to bring economic benefit to AMA members?

MR. COSTILO: Objection, it calls for speculation
[9362] as to the witness' mind. Mr. Bierig speculated all morning as to states of minds of other entities.

JUDGE BARNES: You are in a different area than the direct examination was and I think that is entirely speculative. He doesn't know why the AMA published the article. I gues it was because it is informative or maybe Dr. Ebert is a very excellent writer. Anyway he would be speculating.

MR. BIERIG: As you know, we had testimony the other day about how *Impact* and the *American Medical News* in which *Impact* is published is designed exclusively to advance the economic benefit of AMA members.

JUDGE BARNES: I recall that.

MR. BIERIG: I think as long as we have the very same week someone who published in *Impact* perhaps we could get some perspective on that claim.

JUDGE BARNES: You may ask him if he wrote it for the economic benefit of doctors. Well, I believe you already asked.

MR. BIERIG: I did.

JUDGE BARNES: And a few other questions which are proper but I don't think the last one is proper.

MR. COSTILO: Your Honor, I have not objected with respect to relevance here but I think it should be exhausted because Dr. Ebert in his description has been
[9363] called to testify, give his opinion with respect to advertising and solicitation and the role that the medical society should play in regulating that and these questions are clearly far beyond the scope of direct. He was not called on the Section 4 issue.

JUDGE BARNES: I knew when he was called I thought he was questioning Dr. Ebert's membership

and the facts he can publish an article without being a member but he has gone a little beyond that now.

By Mr. Bierig:

Q. Very well, Your Honor, referring to the question of advertising by physicians, Dr. Ebert, you do recognize that there can be abuses of such advertising, do you not?

A. I would certainly say there can be abuses of any social system including advertising, yes.

Q. So you do concede advertising by physicians can be abused?

A. Yes. Any kind of advertising can be abused.

Q. And you do recognize that advertising by physicians can involve deception of potential patients?

A. I think that I would have to say that, in answer to the question, in fairness to what I have said before, what I believe, that the kind of deception which is practiced at present by people who advertise, physicians, would continue, but if you are asking me, "Do
[9364] I think there would be a great increase in this from legitimate physicians," I do not.

Q. I am simply asking you whether in a general—whether advertising by physicians can involve deception of potential patients?

A. Yes, it is clear because it exists now.

Q. And that deception can include deceptions involving price deception; is that correct?

A. I don't quite know what you mean.

Q. Well, someone to, to take a simple example, can offer a procedure for X dollars and then in fact, when the patient comes in, he says "Yes, that X dollar one was the one I advertised but you really need the Y dollar procedure."

A. Yes. I suppose that could happen.

Q. And will you concede that deception involving advertising by physicians can be quite subtle?

A. Not necessarily, no. I don't understand the question.

Q. Well, you will concede that medicine is a very complex art, a complex art, and that quality, I believe you stated—well, would you concede that medicine is a very complex field?

A. Yes.

Q. And I think you have stated on direct examina-
[9365] tion that advertising of quality can be a very complex issue?

A. Yes.

Q. Oh, so a statement of quality can have very subtle implications, can they not?

A. Statements of quality can have subtle implications, yes.

Q. So there is room for subtle deception in advertising of quality; is there not?

A. Well, you are suggesting, you are making a jump there from subtle differences in evaluating quality from one which really says, "A deliberate exception." I don't accept the fact that the majority of physicians would deliberately deceive.

Q. No, without any intent on the part of physicians to deceive, there can be claims from which false inferences can be drawn; are there not?

A. I am not sure that I would agree with that. I would think the physician would be particularly careful not to make false claims, for the reason of malpractice. I think it would be a great deterrent and I would think he would want legal advice as to what he could say.

Q. You pose the threat of malpractice as a significant deterrent to deceptive advertising?

A. By a legitimate physician, yes, always with that qualification.

[9366] Q. Would you expect malpractice to act as a major deterrent to unnecessary surgery?

A. I think increasingly it will in the future.

Q. Is unnecessary surgery today still a major problem in American medicine?

A. It is.

Q. Would you expect the threat of malpractice to be a major deterrent to the negligent practice of medicine?

A. I think, again, I think it depends on what group you are talking about. But I think it is a deterrent, yes.

Q. But is negligent practice still a significant problem in American medicine?

A. Yes. I mean, I would have to add that I don't think any system of regulation or supervision is perfect. There are always going to be problems with it.

Q. Do you think the threat of malpractice would be a major deterrent to physicians becoming, or practicing while under the influence of a narcotic or while under the influence of alcohol?

A. I certainly would.

Q. And would you, in fact, concede that physicians do practice today under the influence of narcotics or while intoxicated?

A. I have no direct knowledge that they do. Per-

[9367] haps you do.

Q. You have a very high opinion of the competency of all physicians; is that correct, Dr. Ebert?

A. I do.

Q. And for the last 13 years you have been associated with the Harvard Medical School; is that not correct?

A. Yes.

Q. Would you agree that the Harvard Medical School had some of the most exacting admission standards of any medical school in the United States?

A. I think they are not too dissimilar of those of other medical schools.

Q. Not too dissimilar?

A. Very much the same as other medical schools.

Q. I think I once heard you a few years ago saying there were 14 applications for every place?

A. No. As a matter of fact I can give you some more accurate figures than that. I can tell you that Boston University, the University of Massachusetts and Tufts have all had more applicants than Harvard Medical School.

Q. Don't you think that is because people self select out of Harvard Medical School?

A. I am simply giving you the facts.

Q. But would you agree that the Harvard Medical School has some of the finest physicians in the United
[9368] States on its staff?

A. I really like to think so.

Q. Would you agree the physicians turned out by the Harvard Medical School are among the best trained and most competent in the United States?

A. I think that they do reasonably well.

Q. When you say "Reasonably well" would you agree they are among the best trained and highly competent?

A. In don't think any better trained than the majority of medical schools, no.

Q. You don't think they are better trained?

A. No.

Q. So then if someone puts an advertisement in a newspaper stating he is a graduate of the Harvard Medical School, what inference would you expect, would you want a consumer to draw from that advertisement?

A. The knowledge that he graduated from a grade A American medical school.

Q. And what inference?

A. Rather than Guadalajara in Mexico.

Q. And what inference do you think would be drawn from the fact someone graduated from Harvard Medical School?

A. I don't know.

JUDGE BARNES: The ranking of medical schools in the newspaper—I don't know who made the ranking [9369] but Harvard was number 1.

MR. BIERIG: Dr. Ebert just testified the only inference he would want someone to draw is that someone graduated from a good American medical school.

THE WITNESS: Let me make clear what I am saying is, you know, basically I am obviously pleased with the fact that Harvard has been classed as the ranking medical school which obviously has a great deal to do with resources and the number of hospital tools and a whole variety of different things. But frankly I would not want the general public to believe, because a student had graduated from the Harvard Medical School that he was necessarily better than someone who graduated from the University of Arizona.

Q. And do you think it is unlikely that someone would draw that inference?

A. I don't know. I don't think—well, I think a great deal depends on the region of the country.

Q. Well, take your region of Massachusetts, do you think that someone would draw the inference that the Harvard Medical School trained physician is more competent than someone graduating from the University of Maine Medical School if there is such a thing?

A. There is not.

Q. I don't know all of the schools, the Northeastern
[9370] School of Medicine if there is one?

A. There is not.

Q. Can you name one?

A. Tufts and Boston University.

Q. How about some of the less pretentious ones, some of the non-accredited schools of Massachusetts?

A. There are none.

Q. Take the Tufts Medical School, you would think it is unlikely someone would draw the inference that someone trained at Harvard Medical School is more competent than someone trained at Tufts Medical School?

A. Maybe the best thing is to give you some factual information if you would like it.

Q. I certainly would.

A. That is we clearly, in making judgments on the qualifications of people for the faculty, and there are hundreds of these that come through each year for appointment and promotion, I would say the fact that the individual graduated from Harvard Medical School or graduated from the University of Arizona had absolutely nothing to do with the evaluation of his quality.

Q. That is on the part of faculty at Harvard Medical School?

A. Right.

Q. Not on the part of the average man walking the
[9371] streets of Boston, Charleston the MTA?

A. That is right. I am not sure Charlie on the MTA would not prefer to go to a physician from Tufts.

Q. I will have to put that in the report, too. Now you referred to controls on surgery placed in hospitals, Dr. Ebert. Is all surgery performed in hospitals?

A. Most major surgery is.

Q. Is cosmetic surgery performed in hospitals exclusively?

A. Can you define cosmetic surgery for me?

Q. A breast augmentation?

A. The injection of the breast with silicon?

Q. Yes.

A. That is probably not.

Q. An abortion?

A. I wouldn't call that surgery but that is all right. I meant to refer to the breast augmentation.

Q. Now, and are abortions performed exclusively in hospitals?

A. Well, I don't consider abortions an ordinary surgical procedure.

Q. You consider abortions and cosmetic surgery procedures that are performed by physicians?

A. I would say that abortions are certainly performed by physicians. And I would say that plastic
[9372] surgery is done by physicians. The kind of sort of breast augmentation that you are talking about I know of no legitimate physician that would do it.

Q. Would you say that abortion and cosmetic surgery are procedures to which an individual can be drawn through advertising?

A. I would say that with regard to abortion usually the patient is drawn because she perceives the need for an abortion and that she can be drawn, she can be identified of a place to go because of the advertising but, often, as you well know, even when there was no advertising that didn't mean abortions didn't occur.

Q. No, but with respect to a specific place where a procedure can be performed or a particular practitioner to perform the procedure at that place or that practitioner can be—

A. Can be identified.

Q. Can obtain patients through the use of advertising?

A. That is correct.

Q. And how about bariatric physicians?

A. What kind?

Q. Bariatric?

A. What is bariatric?

Q. People who purport to treat fat people.

A. I don't know. I have no information about that [9373] specialty. I don't even know it exists.

Q. You are about to find out.

A. Is that recognized by the AMA as a profession?

Q. Well—

A. They make, you know, they have the rules as to what the recognized specialties are and I don't recall having seen that.

Q. So, in your testimony, you did not consider the fact that there are people who advertise possible cures or treatments for fat people?

A. I recognized that, in my testimony that there were physicians who I thought were unethical in their behavior and did presently advertise and that abviously without any control by medicine at all, but the fact that I recognized that they existed and undoubtedly will continue to exist didn't alter my feeling that that is not the mode of most physicians or the vast majority or 99.9 percent of physicians.

Q. This is the first time you heard of such a thing as bariatric physicians?

A. Obviously I read the papers and see people advertise they can get rid of fat but I never heard it called "bariatric."

Q. You will concede that advertisements can lure individuals to a particular practitioner who holds [9374] himself forth as being able to treat fat people?

A. Yes.

Q. Now you have mentioned surgeons several times in your direct testimony. And you mentioned that they solicit by attendance at staff rounds. To your knowledge, has any medical society ever declared it unethical for surgeons to attend staff rounds?

A. To attend staff rounds?

Q. Yes.

A. No.

Q. And you mentioned that surgeons solicit by giving papers. To your knowledge has any medical society declared it unethical for a surgeon to give papers?

A. Yes, they have often criticized this when it appeared in newspapers.

Q. When it appears in newspapers but—

A. But not as a result of the paper.

Q. But not to give?

A. I can remember a number of other cases in which it was given directly to the press and they were reprimanded. A classic example is Probyasyn. Dr. Ivy, when he first made it public to the press. So that, yes, procedure, and that was not surgical, but procedures where the name has gotten in the paper and has been described even though at a medical society meeting, that there [9375] have been questions raised, yes.

Q. What is the current medical view of Probyasyn as a cancer treatment?

A. It is no good.

Q. You say that physicians are often selected by word of mouth.

A. Yes.

Q. In fact, aren't surgeons selected generally by referrals from primary care physicians?

A. Not necessarily.

Q. But generally?

A. No, I wouldn't even say "Generally." I don't think there are any very good figures on this because you are assuming that most patients have a primary care physician and it is very difficult to get the precise figure. Many patients go directly to the surgeon.

Q. Well, you speak about the figures. You also spoke in your direct testimony about a Robert Wood Johnson Foundation report you had read?

A. Yes.

Q. Do you recall the figure contained in there for the amount of the percentage of American people that did have access to a primary care physician? Was it high or low?

A. I remember a figure that had to do with access to a physician. Whether the definition of that was
[9376] primary care, and I think one has to be rather careful how you define that. The primary care physician may turn out indeed to be the surgeon.

Q. Do you recall the figure was 87 percent?

A. I don't recall it precisely.

Q. But it was high?

A. It was high.

Q. Isn't it true that in your opinion that, Dr. Ebert, primary care physicians, or physicians generally, are in a better position to evaluate the competence of surgeons than would a consumer just reading an advertisement about the surgeon?

A. Well, I would say that they would be possibly better able to judge the competence of an individual

surgeon but as I am sure you are aware, very often that does not mean they necessarily refer to the surgeon they feel is most competent.

Q. I thought you indicated previously that most physicians you know are quite ethical?

A. They are.

Q. So the ethical practitioner would refer a patient to someone he felt was most competent; would he not?

A. Not necessarily. He might refer to one that he felt was perfectly competent but he might not necessarily say it was the best or most highly competent.

[9377] Q. But he would be in a better position to judge competence than would a lay person reading an advertisement about a surgeon who purported to have done various things?

A. Yes. But if I could, Your Honor, if I could just expand on my answer to that, you know, and the answer is obvious, that physician should be better able to judge. However it would seem to me that it might be useful if the patient had information about another surgeon that he could ask his own physician about and get the direct judgment.

Q. And do you have any, well I believe you also stated on direct examination that most physicians are so busy that they wouldn't advertise; is that correct, that having insufficient patients is not their problem?

A. Well, I think what I really said in my testimony was that I think the value of advertising and the significance of advertising is going to be far more around the advertising of various systems of care, of groups, than it is solo practitioners of medicine.

Q. So you will concede that most solo practitioners will not advertise?

A. Except when they are getting started.

Q. Except when getting started?

A. For some of them it is very difficult to get started.

[9378] Q. Now you also mentioned, I believe, as a benefit of advertising, the fact that some marginal or fringe practitioners might be exposed by their advertising; is that correct?

A. No, what I was suggesting was that advertising, or control of advertising does not seem to control this group from practicing. What I said was that it may actually be to some advantage to know that they are not underground, because you know where they are.

Q. And you don't think you will know where they are when when their victims start showing up in hospital emergency room?

A. No, I do not and I can give you specific evidence it is truthful because when I was in Cleveland we had an average of one negative septicemia a week, many of them fatal from women who had criminal abortions and there was no way we could find out where they had them.

Q. You didn't ask them?

A. We certainly did ask them.

Q. The fact that an abortion might have been illegal at the time you don't think cast any uniqueness on the subject?

A. Yes, but you said is it possible to find and obviously if something goes underground there is reason to go underground.

[9379] Q. But you haven't talked to anyone among the California plastic surgeons who have been seeing victims of some of the incompetent plastic surgeons in California?

A. No, I talked do a lot of surgeons in California and I don't recall that ever coming up.

Q. Dr. Ebert, you testified on direct examination that you believed the average consumer has a lot more ability to discriminate about advertising of physicians than we might give such consumer credit for?

A. Yes.

Q. As former Dean of the Harvard Medical School and as a physician who has been involved in teaching throughout your professional career, would you say that you are familiar with most medical journals?

A. No, certainly not.

Q. Would you be able to evaluate the distinctions between various medical journals in terms of their quality?

A. Some, not all.

Q. Not all. How about the average consumer who is not even a physician who has not been Dean of the Harvard Medical School?

A. Well, I guess I am really not following your question. Are you asking "Could I discriminate if I were to read the journals"?

[9380] Q. No, suppose you were to see an advertisement in which someone claims he had published an article in a particular journal, would you be able to make a judgment as to the person's competence on the basis of that?

A. Yes.

Q. You would?

A. Very simply because I would have to know "Is it a referee journal or not" and I can find out.

Q. Do you think most consumers would know the difference between a referee and not referee?

A. But you asked if I could distinguish on that basis.

Q. No, but my next question is, could a consumer?

A. No, I don't think a consumer probably could. But I suspect a consumer could find out.

Q. I am going to show you an advertisement, Dr. Ebert, that has been admitted into evidence as Respondents' Exhibits 680-A and B and it is an advertisement by a physician named E. B. Frankel, M.D., and I am going to call your attention to the second page and I will have to look over your shoulder.

A. Yes. You notice that Dr. Frankel advertises that he is the author of an article entitled "Hair Transplants—Additional Observations," which he states was published in *Cutis*, a dermatology medical journal.

A. Yes.

[9381] Q. Are you familiar with the journal *Cutis*?

A. No.

Q. Would you say that it is a very distinguished journal?

MR. COSTILO: Objection. If he is not familiar how can he say it is a distinguished journal?

By Mr. Bierig:

Q. Have you ever heard of it?

A. No.

Q. What conclusions about the professional competence of Dr. Frankel would you draw from the fact that Dr. Frankel has published an article in "Cutis"?

A. None.

Q. And what inference do you think the ordinary consumer would draw from the fact he published this article on hair transplants in "Cutis"?

A. I haven't the foggiest idea. When you say "Am I familiar with it" you have to remember there are something like 5,000 medical journals.

Q. You say the typical consumer is very discriminating. Do you think the typical consumer is able to discriminate between *Cutis* and dermatological journals in very high repute you have heard of?

A. I think when I say that the consumer is discriminating, I would say that the discriminating con-
[9382] sumer who read that ad would be suspicious just from looking at the ad.

Q. How about the nondiscriminating consumer?

A. I think he could be misled.

Q. Could be misled. Then I call your attention to the next claim in that very advertisement in which Dr. Frankel claims that he is the author of an article entitled "Nerve Block for Hair Transplants" to be published in the *Journal of Dermatologic Surgery* and as former Dean of the Harvard Medical School are you familiar with the journal?

A. No.

Q. You think the average consumer is familiar with the medical reputation of the *Journal of Dermatologic Surgery*? Do you think the average consumer can be misled by that statement?

A. I think—well, no I don't think the average consumer would. I think some might.

Q. Some consumers might be?

A. Yes.

Q. You don't think—

A. I don't think the average one would, no.

Q. You don't think the average consumer would be impressed by the fact Dr. Frankel published these two articles?

[9383] A. No, I doubt it.

Q. Why do you think Dr. Frankel put these in his advertisements?

MR. COSTILO: Objection, same objection, he is going to state of mind of other people and that is improper.

JUDGE BARNES: I think it is improper.

By Mr. Bierig:

Q. Well, would you say the inclusion of these two facts about the publications of Dr. Frankel gives consumers useful information which can help them choose a physician intelligently?

A. No, I don't think it does.

Q. No.

A. But I would also call your attention to what goes on afterwards, that, you know, the majority of consumers are not going to have cosmetic surgery for breast enlargement, lift and reduction; face, eyelid and neck lifts; chin, nose and ear remodeling; abdomen, hip, thigh, arm reduction; hemosurgery; dermabrasion; wrinkle and tattoo removal; scar revision.

Frankly, I don't think the average consumer would be interested in that.

Q. But some consumers would be?

A. Some consumers are interested in anything.

[9384] Q. And perhaps to generate some more interest, Dr. Frankel suggests that consumers allow Dr. Frankel to "Phone me," and you will see the portion from Dr. Frankel says—

A. Phone me.

Q. Not phone me. Dr. Frankel says rather, "I understand you can help me," this is what the consumer says; please send me the following free information including your services and fees and phone me.

Perhaps the phone call might generate some interest on the part of the prospective patient?

A. Your Honor, let me make the general comment about this, because obviously the point you are trying to make is "How many people is this fooling."

Q. Yes.

A. And it is the kind of ad that one is likely to see in rather shady kinds of magazines where, you know,

that you can improve your muscle tone and you can develop large breasts and you can do a whole variety of things and simply the character of the ad is such that the majority of consumers would not be misled.

Q. Do you consider *TV Guide* to be a shady magazine?

A. Since I don't read it, I really don't have a judgment. Was this ad in *TV Guide*?

Q. Not this particular one but many like it. Would
[9385] you consider the *Los Angeles Times* to be a shady publication?

A. No.

Q. Would you consider the *United Airlines Travel Magazine* to be a shady publication?

A. I don't read it.

Q. That does not mean it is not shady?

A. Nor do I know.

MR. COSTILO: I don't think we want to defame any airlines here.

By Mr. Bierig:

Q. Now—

A. It is the character of the ad I am getting at. It is not—well, it is a kind of ad that most consumers realize is attempting to mislead. It is a type of ad. I don't have to be an expert in advertising to know that that is an illegitimate ad. I think a good many consumers would know that.

Q. A good many would but a good many wouldn't; isn't that correct?

A. I think the majority would.

Q. Would it shock you if I told you over $2 million a year was spent by Dr. Frankel on ads like this?

A. No, it wouldn't shock me at all.

Q. Now, you testified on direct examination, Dr. Ebert that you had served on the board that certifies
[9386] people as board certified in internal medicine?

A. Right.

Q. Would you say that you are reasonably familiar with the system of board certification in American medicine?

A. I am familiar with it, yes.

Q. I ask you then to look at the statement that appears just above the claims regarding the two publications which states: Associated Board Certified Cosmetic Surgeons.

How do you interpret that statement?

A. I never heard of it.

Q. Well, there it is.

A. Then I don't know what you mean—I don't know that such an organization exists in terms of a legitimate board such as internal medicine or general surgery.

Q. Is there in fact a Board of Cosmetic Surgeons?

A. Not that I heard of.

Q. But there can be cosmetic surgeons who are board certified in other specialties?

A. They don't call themselves that but plastic surgeons are not cosmetic surgeons.

Q. There can be plastic surgeons saying board certified say in dermatology; is that correct?

A. Rarely. I wouldn't know of any.

Q. You wouldn't know what is meant by associated
[9387] board certified cosmetic surgeons?

A. No, I wouldn't.

Q. Would you think most consumers would know what it means?

A. No, I don't know what they would think.

Q. Do you think they would think it sounds pretty good and impressive?

A. I think anybody that wanted to be misled would be impressed.

Q. How about someone who didn't want to be misled?

A. I don't think the average person reading the ad, and I come back to what it says in the substance of the ad, would be mislead by this. In other words, you are concentrating all on this (pointing). I am looking at the whole ad.

Q. We will go on to more ads than this. Let's go on to the aspects "Member of American Medical Association." What does membership in the American Medical Association say about the professional excellence of a physician?

A. Well, it says that he is qualified as an M.D. and that he has paid his dues.

Q. Does it say that he has received any special training beyond having graduated from medical school and having paid his dues?

A. No.

[9388] Q. There are certain societies in which membership does indicate some special status or training; is that not correct?

A. That is correct.

Q. What would be an example of such a society?

A. American College of Surgeons.

Q. American College of Surgeons. So when you read this and you see "Member of the American Medical Association" what inference do you draw about professional competence of Dr. Frankel?

A. I wouldn't draw any. I would be—well, the only question I would have is "Was he still a member."

Q. If you were to see, instead of "Member of American Medical Association" you were to see "Mem-

ber, American College of Surgeons" would you draw some inference as to the quality—

A. I wouldn't believe it with that ad.

Q. But I just told you, without more, that Dr. Frankel was a member of the American College of Surgeons, what inference would you draw from that?

A. I would like your evidence. I would call up the American Board and find out.

Q. Do you believe that the typical consumer knows the difference between the meaning of membership in the American Medical Association and the meaning of
[9389] membership in the American College of Surgeons in terms of the professional competence of the members?

A. Well, I think that they may, yes.

Q. You do?

A. Yes, I think some do, yes.

Q. Would it shock you to learn that many consumers don't even know what board certification is?

A. No, it wouldn't shock me. I think that I would also say, though, that many do know what board certification means. It is not sort of a secret. Most surgeons and most internists and indeed most physicians are very careful to have diplomas on the wall and the certification there and I think most of them explain what they mean. So I would think it is fairly common knowledge.

Q. Dr. Frankel, though, has not explained what membership in the American Medical Association means in this ad, has he?

A. No.

Q. Now I call your attention to this statement here (pointing), where it is included in the advertisement that, well this is a clip out for the consumer to send in and it says: Dr. Frankel, I understand you can help me.

Now, what do you think of a physician who claims to be able to help a patient without ever having seen or
[9390] talked to that patient?

A. Well, as I say, I mean, I have really answered there in what I said about this ad.

Q. Well, answer it specifically.

A. I think it is a dishonest ad.

Q. And what would you think of the professional integrity of someone who claims that he can help a patient without ever having seen the patient?

MR. COSTILO: Your Honor, I really have no problem with the doctor answering this question because I think it will be a helpful answer really. However, I am a little concerned about defaming a party not before the Court by name, and I want to raise that problem with the Court at this stage. But I just want to raise that issue here. If there is a way of getting at this without dealing with specific individuals I think it would be more useful.

JUDGE BARNES: I don't see any problem. This ad is in public domain and subject to comment by anyone who wants to comment about it.

MR. COSTILO: I have no problem with the doctor answering then.

THE WITNESS: Well, you know, I think I understand you can help me, please send me the following free information—well, let me just make the comment
[9391] that if he spends $2 million on advertising he is not getting his money's worth. This is a terrible ad. He can certainly do better than this.

By Mr. Bierig:

Q. You will notice in the ad he has six locations and that is not bad for—

A. I have realized that but I am simply saying he is not getting his money's worth from the ad. I think it is an inferior ad that is all I am saying.

Q. What about the professional integrity of someone who claims to be able to help someone without having seen or talked to that someone?

A. Well, you know, I would agree with you, if I don't know, if I have never seen the person, obviously you can't make the statement—I suppose that— well, the answer, if you wish, you know, that is what you want me to say, he can't say that, okay.

Q. Okay. I also show you the beginning of the ad since we want to talk about the whole ad entitled "Your appearance really counts" and in the first frame we have a picture of a woman in a rather full view and off to the left in a smaller view the woman in the "before" picture.

A. Yes.

Q. Then we have the rest of the frame that I won't
[9392] describe but I just want you to read the entire advertisement so you will have it all.

A. Do you want me to read it out loud?

Q. No, don't read it out loud. I want you to read that and we have gone over the second half of the advertisement already. I might ask you whether, in your opinion, there is any question of professional integrity raised when the "before" nose is shown in a complete side view and the "after" is shown in a three-quarters view?

MR. COSTILO: Objection, Your Honor. I have not objected up to now with respect to this line of questioning. Dr. Ebert, in his testimony, says there are going to be abuses, there are going to be bad doctors and false and misleading ads. He says this ad (point-

ing) was a bad ad. He said he has some questions with respect to the doctor who would be advertising. He said there are going to be a very small percentage of doctors who do this and that these doctors cannot be controlled by the medical society. I think that this cross-examination is in accord with his testimony and to start going ad by ad here—I have been handed now three or four ads—that is just playing a meaningless game. I would object to further examination on the point.

JUDGE BARNES: Well, I will let him continue another moment or two but I agree we shouldn't go through a long series.

[9393] MR. BIERIG: We won't go through a long series but in this ad it states Dr. Frankel is a member of the American Medical Association and assuming that fact is true—

THE WITNESS: It it true?

MR. BIERIG: It is.

MR. COSTILO: Objection, there was testimony during Respondents' case that Dr. Frankel held himself out as a member of the AMA and I think it was from Dr. Goins and apparently the American Medical Association mistakenly sent him a membership card or something to that effect and there is a big issue on the subject. So I don't think any statement to the witness that Dr. Frankel is a member of the American Medical Association can be made and have the witness answer a question on that factual premise.

JUDGES BARNES: I agree. It is not important whether he is or is not a member but the important thing is it appears in the ad.

JUDGE BARNES: What effect does that have on—

By Mr. Bierig:

Q. No, I have another question here. Assuming he is a member of the American Medical Association you wouldn't consider it unreasonable of the AMA to tell Dr. Frankel to modify this advertisement, would you?

[9394] MR. COSTILO: Objection. There have been objections raised when I questioned the witness with respect to factual matters here. This is calling for rank speculation.

JUDGE BARNES: I don't think so. You may answer it, Doctor.

THE WITNESS: Would you give me the question again.

By Mr. Bierig:

Q. Assuming Dr. Frankel is a member of the American Medical Association you wouldn't consider it unreasonable for the American Medical Association to tell Dr. Frankel to modify this advertisement, would you?

A. I wouldn't. I would have expected if he is a member of the AMA he is required to belong to a local medical society. Does he?

Q. That I don't know but assuming—

JUDGE BARNES: Let's assume he does.

THE WITNESS: All right. Then I would expect the local medical society to ask him that question.

By Mr. Bierig:

Q. Would you expect them to tell him to modify the advertisements?

A. I would think they would do more and frankly I think they would want to know the substance of
[9395] what he is doing. I would be more interested in following up, if they are concerned—since he says he is a member of AMA—well, I am not so worried about the modifying of the ad as what he is doing.

Q. Would you also think they have some concern about what he is saying in the advertisement?

A. I would certainly say so particularly if it is untrue.

Q. Now, Dr. Ebert, I show you an article that has been marked into evidence as Respondents' Exhibit 278 which is an article that appeared in the Springfield, Massachusetts *Morning Union,* on April 7, 1977. It is entitled "Cateract Patients find Quick Cure at Ludlow." This article is based on an interview between the author and a certain Dr. Lee Hirsch who previously has been identified as a member of the Massachusetts Medical Society.

• • • • •

[9398] *By Mr. Bierig:*

Q. Going on to Respondents' Exhibit 278, Dr. Ebert, I call your attention to the, well before I do that let me ask you this question. As Dean of the Harvard Medical School and one who has had overall supervision, responsibility for the supervision of hospitals in the Harvard Medical School family, one of those hospitals is Massachusetts Eye and Ear Infirmary, correct?

A. That is correct.

Q. Do you know whether a surgical technique involving corneal transplants is done in the United States?

A. Yes.

Q. And it is done routinely in small hospitals?

A. No.

Q. Do you know whether eye transplants are done in the United States?

A. Yes.

[9399] Q. Are eye transplants done in the United States?

A. Yes.

Q. Routinely at small hospitals?

A. When you say "Routinely at small hospitals" I think in fairness to Your Honor you have to qualify that a little bit because it clearly, well the answer is not routinely in small hospitals. I can't answer with any authority it is not done in some small hospitals where there is an exceptionally well qualified opthalmologist; I just don't know.

Q. I call your attention to the second to the last paragraph in this article which states, "The eye surgery wing at Ludlow performs a number of other operations including eye and corneal transplants. There are also eye testing and eye donor programs."

Now, assuming that in fact corneal transplants and eye transplants were not performed at the Ludlow Hospital, would you consider it unreasonable of the Massachusetts Medical Society to tell Dr. Hirsch to write a letter to the editor of the Springfield *Morning Union* clarifying the situation?

MR. COSTILO: Object. That statement is filled with assumptions and multiple assumptions there, not only as to what a medical society should do, if it should do anything, but also with respect to the fact that if

[9400] something was not done at this hospital, is that the implication, or the implication is is that correct and if it was not done at a hospital the statement is false. But to ask this doctor here to answer a question phrased in that manner I think is improper.

JUDGE BARNES: It is not improper. If he says "Assuming they are not performed there" the doctor is to assume—

By Mr. Bierig:

Q. Assuming Dr. Hirsch is a member of the Massachusetts Medical Society would it be unreasonable for the Massachusetts Medical Society to tell Dr. Hirsch to write a letter to the editor of the *Springfield Morning Union* clarifying the situation and correcting the mistake?

A. No.

Q. Your answer was no?

A. I hope that was, I mean it was not unreasonable, that was the—

Q. Right. You think it would be reasonable?

A. Let's put it it is reasonable.

Q. I think it would reasonable of the Massachusetts Medical Society to tell Dr. Hirsch to write a letter to the newspaper clarifying the situation?

A. I would certainly think it was reasonable to have the record corrected by whatever means, the doctor
[9401] writing a letter to the editor, certainly it should be clarified.

MR. COSTILO: Your Honor, I think it should be clarified—this question here was phrased in terms of "tell," would it be reasonable for the Massachusetts Medical Society to tell?

Well, I think "tell" can mean many many things. That is very ambiguous. I think that should be clarified here.

JUDGE BARNES: Well, you can clarify it on redirect.

MR. COSTILO: I will.

By Mr. Bierig:

Q. Now, Dr. Ebert, I believe you testified on direct examination that advertising by physicians can give consumers useful information to help them make an informed choice of physicians; is that correst?

A. That is correct.

Q. I show you now a copy of an advertisement that has been admitted into evidence as Respondents' Exhibit 878, which shows a picture of rather scantily clad buxom young woman with the heading, "You don't have to be rich to make the most of yourself. Cosmetic surgery can give you what nature didn't" It gives you various procedures and it purports to be sponsored by

[9402] the Woman's Advisory Council.

What useful information to help a consumer make an informed choice of physicians is contained in this advertising?

MR. COSTILO: Your Honor, I have the same objection.

THE WITNESS: None.

By Mr. Bierig:

Q. None?

A. Because it is not a useful ad. It is a dishonest ad. I want to make it very clear, Your Honor, I never suggested that advertising by itself was always good.

Q. I show you—

A. It is an instrument like any other that can be used or misused and that is misused.

Q. I show you Respondents' Exhibit 809 which is headed, "Come in fat and walk out thin, without strenuous exercise," and again the claim is "I can help you lose 10, 20, 30 pounds or more sooner than you think." And it purports to be sponsored by one Alfred

W. Ferris, M.D., and with a couple of pictures of the Caduceus.

What useful information is contained in this advertisement that will help consumers make an informed choice of physicians?

A. None. Well, there is one use, it would be his [9403] information, though, he is licensed in California and I am curious as to whether—since all of these seem to come from California, what local medical society does the practice of these individuals, not the ads, but the practice—

Q. May I ask what would happen to them under the anti-trust laws if they did—

MR. COSTILO: I move to strike that statement.

JUDGE BARNES: I think it is all right. I might be interesting reading.

By Mr. Bierig:

Q. So you don't take the position, Dr. Ebert, that all advertising gives consumers useful information that will help them make an informed choice of physician?

A. That is what I stated earlier.

Q. And some of it can be rather misleading?

A. Certainly it is.

Q. And some can lure patients into seeing a physician for reasons unrelated to any sound medical necessity?

A. And does.

Q. Do you believe that advertisements containing testimonials about a particular practitioner gives consumers useful information to help them make an informed choice of physicians?

A. Not particularly, no.

[9404] Q. Do you believe that advertisements which are intended or likely to create inflated or unjustified

expectations of favorable results give consumers useful information to help them make an informed choice of physicians?

A. No. Your Honor, if I could go back to the testimonial?

JUDGE BARNES: Yes.

THE WITNESS: I do have to say that ironically that is the way most patients get information. They get it by word of mouth testimonial. But it is not any different in kind.

By Mr. Bierig:

Q. Except when patients get it by word of mouth it is not in a paid advertisement sponsored by the physician and chosen by the physician?

A. No. But I don't mean it makes it any more objective. One thing one can say is that kind of evidence is really poor evidence.

Q. You can't imagine an advertiser giving a testimonial in which the testimonial says that the physician did a bad job, can you?

A. No.

Q. But you could imagine a consumer when asked about the competence of a physician saying, "Well, [9405] that physician didn't do a particularly good job in my case," can't you?

A. That is correct. I can also imagine that could be incorrect evidence. In other words, what I am really saying is that that kind of testimonial evidence, whether by word of mouth, in an ad or whatever, is not good evidence.

Q. I show you a copy of Respondents' Exhibit 785. Mr. Costilo, I didn't give you a copy of this before.

MR. COSTILO: Yes.

By Mr. Bierig:

Q. This is an advertisement entitled, "I just couldn't believe the change, I kept touching and looking at my nose to make sure it was really there," and the advertisement, which is sponsored by the Bosely Medical Clinic purports to be the testimonial of one Martha Macias.

What useful information, if any, is given in this kind of testimonial?

A. None.

Q. Now, going back to my question that we digressed from, do you believe, Dr. Ebert, that advertisements which are intended or likely to create inflated or unjustified expectations of favorable results give consumers useful information to help them make an

[9406] informed choice of physician?

MR. COSTILO: I would like to have it read back since it was quite a long statement.

JUDGE BARNES: All right.

(The record was read by the reporter.)

MR. COSTILO: Do you understand the question?

THE WITNESS: I understand the question. Since it is already edited with a conclusion, I don't disagree with the conclusion.

By Mr. Bierig:

Q. So you don't think this kind, or you don't think that advertisements which create inflated—

A. Advertisements which mislead by inflation or by whatever means do not help the consumer.

Q. Well, do you believe, Dr. Ebert, that advertisements which have self-laudatory comments and imply that a practitioner has skills superior to other physicians engaged in his field of practice give consumers

useful information to help them make an informed choice of physician?

MR. COSTILO: I would like to object. We have a phrase which may have different connotations and I think it should be explained, "Self laudatory."

JUDGE BARNES: The best, the most experienced, self laudatory.

[9407] *By Mr. Bierig:*

Q. Right.

A. Could you give me the question again to be sure I got it.

Q. I will give it to you again. And for "self laudatory" you may use the Court's "the best."

A. Yes, I understand that.

Q. Do you believe that advertisements which are self laudatory and imply that a practitioner has skills superior to others, to other physicians engaged in his field of practice, give consumers useful information to help them make an informed choice of physician?

A. I suppose that they could if they are true and they might be true.

Q. And how can that be measured, whether someone is the best physician in town?

A. That depends on what field, obviously. I suppose it would not be difficult to identify the best cardiac surgeon in Boston, for example, or, on the basis of the record, what his mortality and morbidity was.

Q. And wouldn't the kind of cases that this cardiac surgeon took effect his record?

A. The answer is that that would be taken into account in making the judgment.

Q. Not by a consumer reading an advertisement?

[9408] A. No, but I think that I would go back to the testimony I gave earlier, which is that in some areas

in which highly specialized kinds of care are provided it could be useful to the consumer to have appear what might, to some, seem to be self laudatory on the basis of the record. It could be stated that their results were better and that their results with some explanation of why, yet they could be accused of being self laudatory.

Q. What if a physician took it upon himself, without any objective verification by an outside group or some impartial peer review, which agreed with him, to state "I am the best general practitioner in Boston, Massachusetts," or "I am the best practitioner in Peoria, Illinois," would you believe that gives useful information to the consumer?

A. Again, as I say, not unless he is.

Q. And has any method ever been agreed upon to test who is the best general practitioner in a particular location or who is the best internist?

A. Yes, to some degree.

Q. Have you ever seen any ranking of physicians by their quality in a list?

A. I have seen plenty of informal lists and rankings, sure.

Q. But not that are distributed?

[9409] A. No. They would be unethical now to distribute.

Q. Take advertisements, and you may have mentioned this earlier, but take advertisements which contain incorrect or incomplete facts or implications that are likely to cause the average person to misunderstand or to be deceived, do you believe that such advertisements give consumers useful information to help them make an informed choice of physician?

A. No.

Q. And isn't it true, Dr. Ebert, in your opinion, advertising by physicians will not lower the cost of physician services?

A. That I am not so certain about.

Q. You are not certain?

A. No. I think, I conceive, and again I come back to the point I made earlier, that—because what I would think would be the major use of advertising is not this (pointing), which we are talking about now, which clearly goes on any way, but the ability of groups and systems to advertise in such a way that there might be some savings in costs. It is possible, for example, to demonstrate that certain kinds of practice arrangements do save.

Q. But advertising by individual physicians would not lower the cost of care in your judgment of these physicians?

[9410] A. It could potentially, I suppose lower the fee.

Q. Didn't you tell me in your office that you thought it would have no effect?

A. Well, what I was thinking of, since we talked in my office, is that let us say the surgeon that charges on top of what the insured rate is might well be more hesitant to do that if his prices had to be stated ahead of time.

Q. But you have conceded most of the medical care costs are borne by third party insurers; is that correct?

A. Yes, I think about 70 percent.

* * * * *

[9415] *Redirect Examination*

By Mr. Costilo:

Q. You were asked a question on cross-examination as to whether or not you received any economic benefit for your dues when you were an AMA member—

MR. BIERIG: Objection, Your Honor. I don't believe that was the question.

Mr. COSTILO: I think that was the substance of it or enough—

JUDGE BARNES: Well, I will allow it.

By Mr. Costilo:

Q. At the time you were a member of the AMA,
[9416] were you in private fee for service practice?

A. No.

Q. You testified on cross-examination in response to counsel's question that a medical society should be, I think you used the word "Concerned" about a doctor's untruthful advertising. In your opinion, should a medical society be permitted to expel a doctor for untruthful advertising?

A. I think that what is important here is not the advertising per se, but what the physician does. I would think that untruthful advertising would certainly be the signal to find out whether his behavior as a physician was unethical in terms of his practice. Certainly, if it were, he should be expelled.

Q. But with respect to his advertising, should the local medical society regulate his advertising as advertising?

A. No. I don't think they should. I think, and the reason for that, Your Honor, is not that in the blatant cases (pointing) it might not be useful there, but what is difficult is the gray areas. There is unfortunately the tendency to regulate rather more severely those things you don't happen to like personally, so I think the principle is a dangerous one. As I say, not in these blatant kinds of ads (pointing), but the principle, when
[9417] applied to the grayer kind of area, I think the consequences could be such as to prevent perfectly responsible things from developing.

Q. With respect to RX-278, which you were shown which was the newspaper article about the Ludlow Hospital and an opthalmologist there, you were asked the question with respect to whether a medical society should tell the doctor to do something with respect to this advertising or this article and, Doctor, do you think that a medical society should be permitted to expel the doctor here, who was Dr. Hirsch, from their ranks because of a statement such as this which he gave to the newspapers?

A. No.

MR. BIERIG: I would like the record to note that there is nothing in the record to indicate Dr. Hirsch was expelled.

MR. COSTILO: I am testing the doctor, or not testing, but we are getting into the medical society discipline operation, who should do it.

By Mr. Costilo:

Q. Do you think the medical society should be permitted to order the doctor here in question not to give statements to the newspapers?

A. No. I think, my own feeling would be that the medical society would be within its rights to ask that
[9418] this, if it is misinformation, that the misinformation be corrected, that the doctor would be free to do so or not as he saw fit, but after all they could write that as they wished to the newspaper—

JUDGE BARNES: I was going to say: Couldn't the medical society write to the newspaper and say this is untrue.

THE WITNESS: This is untrue, absolutely. I would think that would be the most direct way to do it.

By Mr. Costilo:

Q. You have spoken about ordering or expelling the doctor. Do you think the medical society should be permitted to discipline this doctor for making statements to the newspaper?

A. No.

JUDGE BARNES: "False statements."

By Mr. Costilo:

Q. False statements to the newspapers, yes.

A. Yes.

Q. Specifically now, with respect to some of the questions which were asked on cross-examination which contained statements, in your opinion, Doctor, are state and local medical societies the appropriate bodies to expel a doctor from their ranks if they decide that a particular advertisement is intended or is likely to
[9419] create inflated or unjustified expectations of favorable results?

MR. BIERIG: Objection, Your Honor. The question has about 12 other questions in it and I would like to know what society is going to expel someone from their ranks if not a medical society—surely, ABA is not going to expel somebody for making a false statement since presumably the physician is not a member of the ABA.

JUDGE BARNES: Let's have the question read.

(The record was read by the reporter.)

JUDGE BARNES: I think you can rephrase that question. "Can a medical society expel a doctor if he makes unjustified claims in ads"—

By Mr. Costilo:

Q. Yes, Should a medical society be able to expel a doctor if, in making an advertisement, the advertise-

ment is concluded by the medical society to be likely to create inflated or unjustified expectations of favorable results?

A. I think my answer, Your Honor, is the same as I have given earlier, that I don't think that using the criteria of advertising is the appropriate criteria for expelling a member. I think an appropriate criteria would be what has actually happened to the patients of the doctor rather than the ad. As I indicated, I said that

[9420] because of the potential that it could be misused.

Q. When you say "It can be misused," what do you mean?

A. The potential that it could be misused in those areas in which some question might be raised where the bias of an individual in the medical society might be such that they would tend to be more severe on a system they were less familiar with or didn't like or was more competitive with them, whereas, I think, on the basis of what the results are, where the medical society then does have that prerogative.

MR. COSTILO: No further questions.

JUDGE BARNES: Mr. Bierig.

Recross Examination

By Mr. Bierig:

Q. You testified, Dr. Ebert, on redirect examination, that you felt the appropriate role of the medical society, in the instance of this Dr. Hirsch, would be for themselves to write a letter to the newspaper explaining what they perceived to be the falsity of the advertisement?

A. I think the Court—I thought that might be a more direct way to do it, but certainly I have no objection to their asking if it is in fact untrue to ask him if he is

going to write and that if he is not going to write that they are going to write.

[9421] Q. What if the ad contained a blatant falsehood, the article just proceeded to give one side of a medical controversy and did not in any way set forth the risks of the side that it advocated or the benefits of the side, that it did not mention—

MR. COSTILO: Objection, Your Honor. I think the question is phrased improperly. We said "what if" and again gives a long statement. I think that it should be more specific—

JUDGE BARNES: I think I understood the question. It was a little rambling. Do you understand it?

THE WITNESS: I think I understand the question.

By Mr. Bierig:

Q. I think I can rephrase it.

A. Well, I think I understand it. The question is, if there is a newspaper article that gives only one side, should there be some correction of it, and I would have to say that too often the articles that appear in newspapers do give only one side of the question, both medically and in the socio-economic aspects of medicine. I certainly think they should be rebutted. But, again, it seems to me that the most direct way to rebut is to write directly and say that "This is false," and I think the medical society has a perfect right to do that.

[9422] Q. Are you going to give the medical society a whole new field of endeavor, that is, rebutting all of the false articles or misleading articles that are not in the newspapers?

A. Is that so bad?

Q. Wouldn't it be easier to have the author or interviewee put—

A. No, I think that would be more complicated.

Q. I show you the advertisements you have looked at, Respondents Exhibits 809, 878, and 680-A and B. Do you suggest that if the advertiser refused to modify his advertisement that the recourse of the medical society is to place counter-advertisements in the newspapers or media in which these appeared?

A. I would say that it is the function of the medical society to write and, if necessary, particularly in California, quite honestly, and to ask—if it is the *L.A. Times* where the ad is, and the publisher of the ad is a physician—to ask them to write a series of articles and, indeed, to do some investigative reporting on these. I think it is perfect—well, I think they are remiss not to do it.

Q. If they asked a physician member to correct some of these inaccuracies or falsities and the physician member said "I am not doing it," do you believe [9423] that the medical society would have no right to censure that individual?

A. Wait a minute—

MR. COSTILO: Objection to the question, Your Honor. First of all, with respect to these types of ads, I think he testified that these were the type of people that were on the fringes and not subject to medical society discipline. I think your question assumes a fact which was not the basis of his testimony here.

JUDGE BARNES: I think you can make a clearer question and give him the assumptions and assume he was asked to correct his ad that was made that way and assume that he failed to do so, then should the medical society have the right to expel him—

By Mr. Bierig:

Q. Let me ask you this question. I don't think there has been any evidence that anyone has been expelled ever from any medical society.

Let me ask you this question then. Assume Dr. Frankel, who is the author or who is the sponsor of RX-680-A and B, was told by the medical society to correct some of the problems in the advertisement that we discussed and assume further that Dr. Frankel is a member of the local medical society and assume further that Dr. Frankel said to the medical society, "I refuse to correct these statements; they are my ads,
[9424] and I am not changing them," do you believe that the medical society should have the right to censure Dr. Frankel for his refusal to correct the advertisements?

A. As I indicated earlier in my testimony, I think that is an inappropriate role for the medical society. I indicated the reasons why I thought it was.

I thought there were more direct ways of dealing with a person like Dr. Frankel, first of all, substantively as to what he does, and secondly, I would think it perfectly appropriate if this was in the *L. A. Times*, and I don't know where it came from—

Q. It could have come from any of a number of—

A. But to also ask those papers to write the articles in rebuttal, not only of this specifically but of this kind of advertising—in other words, frankly, I don't think you are going to control the Dr. Frankels of this world by censoring in this fashion, but you can control them more by publicizing the fact that this is a fake because who in the general public, and I will give you your own argument, is going to know he has been censored?

Q. What medical society has the money to put into counter-advertisements?

A. They don't have to put in counter-advertisements but go to the newspapers and ask, as I say, that there be an investigation of this and that, a general article [9425] appear on this. I don't think it has to be—

Q. Your opinion is that the—

JUDGE BARNES: Well, I think we have about exhausted this line of questioning.

By Mr. Bierig:

Q. If Dr. Frankel told the local medical society that he was going to continue to be a member of the local medical society and they can "Go fly a kite" with respect to their requests on advertisements, the medical society would be totally impotent to discipline Dr. Frankel for the advertising? That is what you are suggesting?

A. They are certainly not totally impotent to discipline him on the basis of what he does, which is more important, much more important than what he does on the advertising certainly. I would assume, since you have these ads here, that there have been complaints about this kind of cosmetic surgery and there are individuals who have been injured by them. I would certainly, on the basis of that, discipline Dr. Frankel.

Q. But you would not discipline him for—

A. Why not do it directly on what he does, not what he says.

Q. No further questions.

MR. COSTILO: No further questions, Your Honor.

JUDGE BARNES: Thank you, Dr. Ebert.

Excerpts Of Testimony Of Stephen Biering, M.D.
Tr. 9533-34, 9545, 9547-48

[9533] *By Mr. Costilo:*

Q. Were you ever in private practice, Doctor Biering?

A. No, sir.

Q. Doctor, if a physician's advertisement in a newspaper is truthful but done in bad taste, is it appropriate for the local medical society ethics committee to declare the advertisement unethical?

A. If it is truthful and not in bad taste?

Q. It is truthful, but it is in bad taste.

A. I think the local medical society would want to individualize its review of every case of that sort and discuss it with the physician. And I'm not prepared to say how they would conclude in any individual case [9534] given whatever circumstances may have entered into the matter.

Q. Is it appropriate for them to take disciplinary action against the physician who has advertised in the newspapers in a truthful fashion but in poor taste as judged by the local medical society?

MR. BIERIG: Judge, that was the same question that was just answered.

PRESIDING OFFICIAL: Well, Doctor Biering said that the medical society should discuss the situation with the physician. And let's assume that it was determined to be in bad taste and the physician refused to change it. What should the medical society do in your opinion, Doctor?

THE WITNESS: I think under those circumstances, Judge Barnes, that the medical society should reprimand the physician through the appropriate committee. And I wonder if one may dialate upon the term disci-

plinary action from that. I wonder if you realize how limited the medical societies range of disciplinary action is. The extreme is to ask the physician to leave the society.

They can't jail anybody, access fine, demand retractions. Any form of realistic punishment that is available through redress in the courts is certainly not available. So I think that since the remedies are relatively mild that are available to the medical society, they ought to be exercised to the full of indicated.

• • • • •

[9545] JUDGE BARNES: Well, I think this is a short one. Should physicians compete on the basis of—

MR. COSTILO: Price, quality and service?

THE WITNESS: If it were possible to equate quality service and price, I presume it would be all right if physicians were in the business of selling a defined product and a standard such as a two-door car of some kind. But, that isn't the case. I believe it would be inappropriate for physicians to do that. I believe it would be inappropriate for lawyers and ministers to do that.

MR. COSTILO: No further questions.

Redirect Examination

By Mr. Bierig:

Q. Going to the last question that was asked you by Mr. Costilo, Dr. Biering, do you believe that the physicians should strive to give their patients the highest quality care they can render?

A. Yes.

• • • • •

[9547] Q. In your judgment, Dr. Biering, would allowing physicians to engage in these activities enable them to compete with each other in a way that would allow customers to make meaningful choices of physicians?

MR. COSTILO: Objection. That's very leading with his specific suggestions.

JUDGE BARNES: Well, I'm going to overrule your objection at this point.

THE WITNESS: Well, let me say first that I don't believe physicians should compete in the commercial sense under any circumstances, and particularly not in the way that solicitation is defined here, which includes the making of testimonials and the portraying of inflated or unjustified expectations or end results, antidotal and self-laudatory information and potentially incorrect, incomplete facts.

I do not believe that this is in the best interest of the public or the profession and that it certainly would not lead to better and more informed choices. As we said earlier, it's difficult enough to make informed judgments on the basis of factual information in this area.

Q. And when you say that physicians should not compete in the commercial sense, what do you mean?

[9548] A. I mean by that that a physician would say, come to my office. You can get better, quicker and at less expense. I use a less expensive hospital and so on than my colleague across the street, which precisely is what commercial advertising does. It exhorts the public to buy something because it is cheaper, better, more available, etc. And physicians, simply, are not in the business of selling a product or guaranteeing results.

Q. Now, you stated earlier, Dr. Biering, that there was no available source of written information on fees. Are patients, to your knowledge, able to receive infor-

mation about physicians' fees before undergoing treatment by a physician?

A. I believe Mr. Costilo's questions was phrased that there were a generally and broadly available information on fees. And I said I believe not. But, any patient can certainly call a specific physician and talk with him or his aides and find out honest answers to a question concerning fee structure in that physician's office.

MR. BIERIG: If I can have one more moment. No further questions, your honor.

MR. COSTILO: No further questions.

JUDGE BARNES: Thank you, Dr. Biering.

Excerpt Of Testimony Of Robert B. Hunter, M.D.
Tr. 9660-9661

Cross Examination

[9660] *By Mr. Barney:*

Q. Doctor Hunter, with respect to your testimony on direct regarding A.M.A.'s current position on advertising, didn't you tell Mr. Costilo and me in our interview last week that it is A.M.A.'s position that physician advertising is not prohibited providing it is reasonably tasteful and factual?

A. What I told you was my opinion regarding the tastefulness. The statement of the A.M.A., the policies of the A.M.A. is included in this document, which I read from to you earlier.

Q. Did you not tell us, though, and spend a considerable amount of time going over particular types of advertising indicating that it was A.M.A.'s position that physician advertising must be not only factual but tasteful?

A. That's a personal belief on my part.

Q. Wasn't that your opinion or your view at that [9661] time of A.M.A.'s position?

A. We have made public utterances to that effect.

Q. By we, you mean A.M.A. officials?

A. Yes.

Q. Didn't you also tell us in our interview last week that most state and local medical associations have accepted A.M.A.'s position that physician advertising should be both tasteful and factual?

A. I believe that is the policy of most states, either written or unwritten.

Q. Didn't you tell us in our interview last week that the state medical associations play an advisory role to

the local medical societies in regulating physician advertising?

A. When consulted.

Q. That is your present view as well, is it not?

A. Yes.

Excerpts of Testimony of Robert Stone, M.D.

[ ] Q. You testified to the role that you feel that medical society should play with respect to regulating advertising by physicians, is that correct?

A. Yes, sir.

Q. You think it is appropriate for a local medical society to discipline a member for sending out announcements, cards to the lay public giving his name and address and office hours?

A. One time doing that is customary in certain localities where I have had any direct experience. It is a usual kind of activity. The medical society will often supply them, and I think it is the usual practice to supply those lists of physicians in the community to whom the announcement was presented.

Q. My question was directed to the lay public sending out cards?

A. That's totally unfamiliar to me. I would think [ ] that it would be that that's really—I don't know what other purpose that would serve except to solicit patients, and I think that would be objectionable.

Q. Do you think it would be appropriate for medical societies to discipline a physician for doing that?

A. In my opinion it would be, but it would be decided by the membership of the society or by whatever the review subcommittee is.

PRESIDING OFFICIAL: How about your personal view, Doctor?

THE WITNESS: My personal view is that is undesirable practice. I would like to see it happen.

By Mr. Costilo:

Q. Do you think, Doctor, that it is appropriate for a local medical society under the existing framework to

discipline a member for advertising in the newspaper his specialty, office hours, and name for a period of a month?

MR. BIERIG: Objection, your Honor. I don't know what Mr. Costilo means by under the existing framework.

By Mr. Costilo:

Q. As a local medical society which performs disciplinary functions in this country?

A. Yes, sir, I believe so, because I don't believe that the repetition of the advertisement brings any new useful information that would help the patient in the [ ] selection of a good physician for that patient.

Q. Do you think it is appropriate for a local medical society to discipline or to reprimand a clinic such as the Mayo Clinic for advertising?

MR. BIERIG: Objection, your Honor. I think Mr. Costilo should specify what kind of advertising he means, and if he means discipline or if he means—

MR. COSTILO: I said reprimand.

PRESIDING OFFICIAL: Reprimand a clinic?

MR. COSTILO: Yes.

PRESIDING OFFICIAL: For advertising?

MR. COSTILO: Yes.

MR. BIERIG: I think he should specify what kind of advertising.

By Mr. Costilo:

Q. For advertising what services it performs?

A. Yes, sir, I do on the grounds that I previously stated that that is soliciting business, and I think that

that's not going to enhance the care of the patient. I think it is likely not to give an objective statement, a useful statement to the patient. Even under the most careful circumstances, it is subject to misinterpretation by the patient.

Q. I take it your answer is the same even if the contents of the advertisement are true with respect to the Mayo Clinic?

A. Yes, sir. The issue is not the truth of the con-
[ ] tents. It is the interpretation that the patient applies to those true statements.

Mr. COSTILO: No further questions.

Excerpt of testimony of William Helme, M.D.—Tr. 7254

Q. Under the Code of Ethics of Maricopa County Medical Society, are members allowed to advertise factual nonmisleading information in the newspapers?

A. I believe not. The trouble with that statement is you put it, what would be nonmisleading and who is to determine it. Actually nobody does that because it is not permitted under the present code.

Q. In Maricopa County does the medical society permit a physician to announce the opening or closing or change of an office in the newspaper?

A. I think not. I am not absolutely sure about that. The usual way is to circulate an announcement to all the physicians in the community. I think it is not done in the newspapers.

Testimony of AMA Consumer Witness # 1 (Tr. 6695—6722)

[6695] JUDGE BARNES: I will receive Respondent's Exhibit 878 in camera, and the exhibit is offered and received for the purpose of identifying our first witness today, who will be referred to in all briefing as Witness No. 1.

(The paper referred to was marked Respondent's Exhibit No. 878, and received in camera.)

MR. BIERIG: Your Honor, as our first witness this morning, we call Witness No. 1.

WITNESS NO 1, was thereupon called as a witness for the Respondent and, having been first duly sworn, testified as follows:

Direct Examination

By Mr. Bierig:

Q. Have you ever undergone cosmetic surgery?

A. Yes.

Q. For what purpose?

A. For the breast implants.

Q. And about how many operations have you had for that purpose?

A. I've went through nine surgeries so far.

JUDGE BARNES: I didn't get the title or the name of the operation.

MR. BIERIG: Breast implant.

[6696] *By Mr. Bierig:*

Q. When was your first operation?

A. September 20, of '76.

Q. How did you decide to have cosmetic surgery?

A. I found an ad in the Sunday paper, Women's Advisory Council, and my husband and I had talked about it and then we had called Women's Advisory Council and set up an appointment to talk to them about it.

Q. Do you recall what information was contained in the ad that you saw in the Sunday paper?

A. It was to the effect—in other words, through surgery, you could have breast surgery or face surgery or tummy tucks or nose jobs—you know. I can't remember word-for-word what it said.

Q. I show you now a copy of what has been marked as Respondent's Exhibit 877 and ask whether this is the advertisement that you saw?

A. Yes, it is. In fact, I brought it in.

(The paper referred to was marked Respondent's Exhibit No. 877 for identification.)

By Mr. Bierig:

Q. And is this the advertisement which you answered?

A. Yes, it is.

MR. BIERIG: Your Honor, we offer into evidence [6697] Respondent's Exhibit 877. I should note for the record that we did not have this until this morning and complaint counsel has agreed to allow us to introduce this into evidence even though we hadn't shown them a copy until this morning.

JUDGE BARNES: We don't see on here the newspaper in which it appeared. Could you tell me that?

By Mr. Bierig:

Q. Do you recall which newspaper it was?

A. It was "The Times".

Q. "Los Angeles Times"?

A. Yes.

Q. And do you recall roughly the date?

(No response.)

By Mr. Bierig:

Q. Just generally the month and the year, if you can recall?

A. It was in August of '76.

JUDGE BARNES: Any objection to the exhibit?

MS. MALESTER: No objection.

JUDGE BARNES: I'll receive Respondent's Exhibit No. 877.

[6698] (The paper referred to, heretofore marked for identification Respondent's Exhibit No. 877, was received in evidence.)

JUDGE BARNES: Before we go any further, I'd like to ask the witness to look at Respondent's Exhibit 878, and is that the correct information about yourself?

THE WITNESS: Yes.

JUDGE BARNES: Thank you.

(Next page is 405)

By Mr. Bierig:

Q. After seeing the advertisement that you answered, what were your expectations about cosmetic surgery?

A. Well, I was to understand that it was a very simple surgery; they would put my implants, my bust would be back to the size it was when I was younger, and I really didn't expect any problems because I was told there wasn't going to be any.

Q. What influence, if any, did the advertisement have on getting you to go the Women's Advisory Council?

A. It had all the influence in the world because up to then I didn't really know it could be done to anyone except for movie stars.

Q. Did you set up an appointment with the Women's
[6699] Advisory Council?

A. Yes.

Q. Who did you talk to there?

A. To Maurice and his wife, Vicky.

Q. What were you told at the women's Advisory Council?

A. About procedure? Just that it was a very minor procedure; it was no worse than going to a dentist and having my tooth pulled; that it could be done right in the doctor's office, and that's when I told him I am deathly allergic to anything in the "caine" family—novocaine or xylocaine or anything. And I was told there that that would be no problem whatsoever, that they could arrange for the sodium pentathol.

Q. What if any pictures were shown to you at that time?

A. They had shown us all kinds of pictures of women who had had breast surgery, before and after

pictures; pictures of women that had had face uplifts and tummy tucks. In fact, they had tried to talk me into having a tummy tuck because I had just lost 52 pounds, and they decided I needed it, too, and I said I didn't want to go in for an additional $1,500 worth of
[6700] surgery. The breast implants alone were going to run fifteen hundred.

Q. How did you know the breast implants would run you $1,500?

A. Maurice at the Women's Advisory Council told us so.

Q. What, if anything, was told you about the amount of time the surgery would take?

A. I was told I would be in and out of the office within an hour.

Q. And what, if anything, was told you, told to you, about your bust size after the operation?

A. I was supposed to go back up to a 36D.

Q. What, if anything, was told to you about the difficulty of the operation?

A. There wasn't to be any difficulty. It was explained to me that they would make a half-inch incision, and the implants would be put in; that for the first two weeks after surgery, as long as I didn't put my arms over my head, such as to brush my hair to to pick up anything exceeding over five pounds, that I wouldn't have any trouble, and I only had to do this for two weeks and then I could go back to everyday activities and back to teaching.

Q. What, if anything, was told to you about the amount of scarring that you would be left with?

[6701] A. I was told there would be no scars at all; that you'd have to take a fine magnifying glass to even tell if there had ever been an incision.

Q. What, if anything, was told to you about the quality of the job that would be done on you, the quality of the surgery that would be done?

A. I was told that it was going to be an A-1 doctor, I had nothing to worry about whatsoever.

Judge Barnes: Who was Maurice? Was he a doctor? What was his position, do you know?

The Witness: I had thought that he was a doctor, when I first talked to him on the telephone, but I find out he—

JUDGE BARNES (interposing): What did he tell you when you went there?

THE WITNESS: He told me he was representing the doctors; that the doctors did not have the time to set up interviews with different people. In other words, we were going for a pre-consultation and to go into the doctor's office, it would—you know—cost us for the doctor's time, and this way they were doing a service for the doctors.

By Mr. Bierig:

Q. Did you finally decide to undergo surgery?

A. Not that evening. We went home and talked
[6702] about it, and we set up another appointment with them.

Q. When you say them, you mean the Women's Advisory Council?

A. Yes, we had told them we wanted a few days to think about it and they called me about two days later and set up another appointment with us to come back in. And even after they set up the appointment, I was kind of hesitating, mainly of the money part. And then we went ahead and went ahead with the appointment. We went back.

Q. Who performed the surgery?

A. They sent me to a Doctor Lipton.

Q. Prior to the surgery, did either of the Women's Advisory Council or Doctor Lipton advise you in any way about the risks of cosmetic surgery?

A. I was told there wasn't any risk.

Q. Prior to your surgery did either the Women's Advisory Council or Doctor Lipton advise you in any way about the complications of cosmetic surgery?

A. No.

Q. Could you describe for the court the hospital in which the surgery was performed?

A. It was horrible. It was a very dirty place. When I had went in they give you a form and things
[6703] to fill out. Their main concern was when my last menstrual cycle was. I had down on the form that I had—you know they say "what surgeries have you had?"—I had down there that I had a complete hysterectomy and yet they were still concerned. And I said eight years ago was my last one. Then they sent me to a lab and there the lab technician that took the book, again, he wanted to know when my last menstrual cycle was. I told him, I said, "Eight years ago". He said, "Oh, come on, lady", and I said, "I had a complete hysterectomy eight years ago." And he says, "All right, have it your way." So, he took me down a hallway, which the walls were all—plaster was coming off the walls, and paint—the smell was atrocious; it was like incense, very, very strong incense. They took me into a room that had two beds in it and Dr. Lipton come in. I said, "I'm really upset about this menstrual period being brought up". He told me, he said, "Don't worry about it." He said, "They don't know what they're talking about."

I put my gown on, they brought a gurney in for me, met the anesthesiologist out in the hallway where he proceeded to give me the anesthetic, and as they were
[6704] getting ready to wheel me into a room they were wheeling another woman out of the room. They were taking me in and the surgical table still had sheets and things bunched up, you know, in a ball, on top of it. Well, then I wont out. I don't remember ever being put on the table or anything.

The next thing I knew, I woke up, I had blood all over my face because they removed two moles, one on my eye and one here (indicating). I had blood on my face and down my neck and I was throwing up, mainly on account of the incense smell. I had a colored nurse screaming at me to get the hell out of that bed and go to the bathroom and throw up. She wasn't going to clean my mess up.

I fell getting out of the bed because the bed was up high and I landed on my knee and she yanked me up by my right arm and told me to get into the restroom. I told her that somebody had messed all over the toilet; she told me I wasn't pregnant, to clean it up. I told her I wasn't cleaning up anybody's shit, and I went over to the telephone and I called home and told my son to have my husband come right after me and get me out of there.

When he showed up at the hospital we waited around and waited around and he told the nurse that we was
[6705] waiting on a wheelchair, and she told him I didn't need a wheelchair, I could walk out. I said, "I don't have to have a wheelchair?", and she said, "If you can't walk out, you don't need to leave."

Q. How long before the time that you were walking out had it been that you received the anesthesia?

A. About an hour and a half, two hours at the most.

Q. And how were you feeling at that time?

A. Very, very groggy. It takes about 12 hours for me to come out of an anesthetic.

Q. Did you subsequently learn why the individuals you've described kept asking you about your menstral cycle and made the references to pregnancy?

A. It was an abortion clinic and that's all they did there.

Q. When did you next see Doctor Lipton after your discharge?

A. I had the surgery on the sixth, and I went back in his office then on a Friday, which he removed the stitches. I went back again on Tuesday because I had an opening, about a half inch.

Q. An opening in what?

A. Underneath by breast where they had put the [6706] implant. The scar was about an inch long and half of it was open.

He told his nurse to bring in a shot of xylocaine.

Q. Weren't you allergic to xylocaine?

A. Yes, which he knew because that's why he had put me in a hospital.

I asked him what the xylocaine was for and he says, "Well, I want to resew you up", and he says, "This is to deaden the pain." And I told him there was no way he was giving me that shot. I said, "You know I go into convulsions." Even from the skin tests they took I wound up having convulsions in the hospital. And he told me, "Well, it has to be sewn up." He said, "I'll tell you, if it isn't closed up by next week you're getting the damn shot if you want it or not."

You don't want me to say what I said to him, do you?

P. No. Tell me what you did after that.

A. I left his office, went home, and my husband and I called Maurice at Women's Advisory Council and we

went in to see him where he had his wife examine me, and he had said well, he was having a lot of problems with Lipton, that he was bringing lawsuits against him
[6707] because he messed some other women up and for me not to go back to him. He was going to send be to a Dr. Sharber, which was supposed to have been Chief of Staff of Plastic Surgery of Martin Luther King—

Q. (Interposing) Martin Luther King Hospital?

A. Yes. He set up an appointmnt on October 5, and I had went to what was supposed to have been Sharber's office but it was also a Dr. Amar's office and we seen Dr. Amar.

Q. Before we get to that, did you ask Maurice why he sent you to Dr. Lipton if he had been receiving all these complaints about Dr. Lipton?

A. Yes, but he said that he never got any of the complaints until after I had had my surgery, and he wanted me and my husband to go ahead and sign papers with his lawyer so I would not have to pay Lipton.

Q. How long after you had had your operation from Dr. Lipton did Maurice tell you this?

A. Six days.

Q. And then I believe you stated that you saw Dr. Amar?

A. Yes.

Q. What did Dr. Amar do?

[6708] A. He said there was no problem, he would have to remove the implants because they were put in wrong, and he said he could do the surgery there in his office. Again, I explained to him about being allergic to novocaine and xylocaine, and he said there was no problem there because they did give sodium pentathol.

They had taken a blood test and discovered my—you know—blood count and stuff was down and my blood pressure was up, and he put me in Bella Vista

Hospital. I went to Bella Vista Hospital in the morning and didn't have surgery until about 9:00 o'clock that evening, where he removed the implants.

Q. Prior to—let me just ask you one other question—did you have subsequent operations from Dr. Amar?

A. I don't understand.

Q. After this operation where he removed the implants, did you have any other operations performed by Dr. Amar?

A. Yes; five.

Q. Prior to this first operation that you just mentioned, or the others, did Dr. Amar advise you in any way about the risks of surgery?

[6709] A. No, he just said that there would be no complications, that everything was going to be all right, just leave it in his hands, for me not to worry whatsoever, he would make me look just as good as I did when I was a teenager, and on and on like that. But, nothing that I was going to have problems. And when I would talk to him about problems I was having he always referred to, "well, it was Lipton's fault." Lipton had went in and cut the pocket out wrong, even though he kept doing surgery on me.

Q. And after this first operation that you just mentioned from Dr. Amar, what medications, if any, did he prescribe for you?

A. Percodan is what he put me on, and he gave me a prescription for sleeping pills and an antibiotic. But the percodan was on a script; in other words, it wasn't just a prescription, it was a script.

Q. What do you mean by a script?

A. Well, we asked the druggist and the druggist said a copy of it had to go to the Narcotics Bureau and the police department and different places copies of it went to.

Q. For how long did you continue to take percodan at Dr. Amar's orders?

[6710] A. I was on percodan from October until January.

Q. Could you describe your state during this time?

A. I couldn't function. I couldn't get up out of bed alone. My husband would have to help me into the restroom or I'd have to wait on one of my children to come home to help me. I literally stayed in bed. I couldn't even think clearly. When I asked him about—I was still in a lot of pain even though I was taking them—he said that not to worry, this is the way he wanted me, this was the only way to keep me relaxed and down in bed. He decided that my nerves was still really shot.

Q. Your nerves?

A. Yes, because I would have nightmares of the surgeries and I'd wake up screaming, or I'd have my husband waking me up at night, patting me, telling me it was O.K., because I'd be crying in my sleep. I'd get up, I'd be having a nightmare and the next thing you know I'd be hitting the wall because I had jumped out of bed and would be running into the wall.

He kept saying that this was to help keep me down and it was supposed to help the pain. He did give

[6711] me some tranquilizers, which I don't know the name of, but they were 50 milligrams of something, because he had said the other ones wouldn't be strong enough anyhow. I did take one of them, which at that time I couldn't raise my arms, even though I wanted to. I couldn't talk; I'd think I'd be saying something to the kids and yet it wouldn't come out. It was very, very frustrating. It was just like everything was in dimension—like if I was there and yet nobody knew I was there. This is the way I felt.

Q. You mentioned that you had five operations from Dr. Amar. Could you describe these for the court? What happened to you during this period of time?

A. During the surgeries?

Q. Yes.

JUDGE BARNES: Over what period of time, how often the surgeries occurred.

By Mr. Bierig:

Q. There was five others after the first one, I believe you testified?

A. Yes.

Q. Let me ask this: How long after the first operation that Dr. Amar performed did he perform [6712] the second?

A. He didn't perform the second surgery until November 22, which at that time all he did was he put me in the hospital and was supposed to be removing scar tissue. Then he put me in the hospital again in December.

Q. How long ago after the November 22 operation?

A. This was approximately December 6 he put me, I had the next surgery.

Then, he did surgery again on the ninth of December.

Q. Three days later?

A. Yes, but in between the two surgeries they were giving me blood. Now, I have AB-RH negative blood, which is a very rare blood. Prior to that I had seen a deal on television about not receiving paid blood on account of the different diseases it can cause, it was gotten from Skid Row.

The first deal of blood I got did not have the paid blood marked on it, where the other three did. I had panicked, absolutely went hysterical.

Q. When was that? When did you panic?

A. Getting the blood. I told them I didn't want it.

Q. Was this paid blood?

[6713] A. Yes. Amar informed me that I had to have it because I had lost so much blood. I like to died from the loss of the blood. A guard—in fact, my husband was there, and a guard came by and rapped on the door with his stick and he said, "It's time to go home", and I really went hysterical. And I said, "Well, if he's leaving, I'm leaving too". I didn't want this blood. I couldn't control myself. I knew what I was saying and I knew I shouldn't be screaming and yelling, but I couldn't stop. I didn't want the blood.

They explained that with having the AB-RH negative blood that they couldn't get it anyplace else and that it was completely screened and the blood was O.K. and they more or less reassured me that the blood was all right.

Then, like I said, on the ninths, he did another surgery.

Q. And what was that surgery?

A. I don't know. He put implants in on the sixth. Then he took me into surgery on the ninth and I'm not sure just what he did. He took the implants back out again; I don't understand just why. And then he put them back in.

Then on the twenty-second of December they put

[6714] me back in the hospital, and Amar was supposed to be doing surgery on me—Dr. Amar—and they—Milt, which is the anesthesiologist, has a very hard time finding my vein—so, he had 36 of these little plastic needles in my body trying to get into a vein. In the meantime, they strapped me down, they greased up this metal sheet and put underneath me, which was explained to me that that was to "ground" me.

Anyway, I woke up before the surgery was over and young Dr. Amar, Dr. Amar's baby brother—in fact,

that's what we call him, baby brother—was doing the surgery. Dr. Amar wasn't doing it.

All right, he put the implants back in, but he also was in ther removing scar tissue. I wound up with a large opening—not an opening at that time, then it was just a dark purple area—on my right breast, one on top of it and one the size of a half dollar below it.

We went to Amar's office right after Christmas, Amar wasn't there, but Milt, the anesthesiologist was, and he explained that young Dr. Amar had to remove so much scar tissue that he only left two layers of skin and it was a very thin surface and this is what the problem was.

[6715] In January—

Q. (Interposing) Would this be January of '77?

A. (Continuing) Yes, in January of '77, Amar said I had to go through more surgery because he had to close these areas up. There was nothing at all wrong with my left breast, it was fine, it was just the right breast.

He put me in surgery and I had decided I didn't want it. I didn't want him doing any more on me. They brought in a shot of—you know, the stuff to put you—before they take you into surgery, pre-op shots—and I decided I wasn't going to take them because I wasn't going to let Amar do any more surgery on me. I was already in the hospital.

I called my husband at work, I told him I wasn't going to go through with the surgery, there was no way, I didn't give a damn if I died, I wasn't going through with the surgery, for him to come and get me. And he said, all right, he'd leave right then to come and get me.

Amar had a young assistant, and I can't remember his name—he come in and he told me all I was doing

was getting myself worked up and bringing my blood pressure up and why didn't I want the surgery and I
[6716] told him, "I can't see where it's doing me any good. Every time I have it, I get worse." And he told me I had to have the surgery. And I said, "No, there's no way", and by then I was packing up my stuff to leave the hospital. And he said he was going to give me a shot to calm me down because I was too worked up, I was radical, I didn't know what I was saying. He gave me a shot and the next thing I knew I woke up in surgery and they were sewing up my left breast.

Q. Your left breast? This was the one that was O.K.?

A. Yes. I screamed so loud—now, the hospital is large—not a large hospital, but it was a ways up from where my room was, and my husband was in my room and he heard me screaming.

Q. You mean you were in the operating room and he was in your room?

A. Yes—"I want to know what in the world you've done surgery on my left breast for? There wasn't anything wrong with it." And he says, "Well, we had to make sure we had clean implants on both sides." Milt had given me more sodium pentathol to put me back to sleep.

Then, when I went back to my room I had told Jim
[6717] they made me go in for surgery, I didn't want it, and I wanted to get out of there, I wanted to go home.

Well, I stayed the night and the next day I went home. And a couple of days later I had to go back to Amar's office because they never done anything about this hole up here (indicating).

Q. Could you describe the condition of your breasts at this time?

A. Very painful, twice as small as they had ever been because Amar had cut away quite a bit of skin

and the right breast, underneath and on the top of it was purple; the odor was very, very bad. My mother had gangrene of the leg and the foot, and that's what the smell was. And Amar kept saying, no, it wasn't gangrene, that it was just the prosthesis, that the skin was so thin that it was just the prosthesis coming through and the odor was from the prosthesis. And he said he was going to put me back in the hospital and do more surgery.

We went in his office on a Wednesday and he told me to check in the hospital Thursday and he was going to do surgery on me Friday. So, we left there and went on home and my mother-in-law was supposed to pick me up the next morning and take me to the hospital,
[6718] and I said no way, I wasn't going. I went over to Los Alamitos Hospital, which is down the street, I can see it from my house. I went there to the emergency room and seen a doctor there and he had three other doctors come in and look at me and they got on the phone and made all kinds of phone calls until they got ahold of Dr. Luhan's office. Dr. Luhan's office said that Luhan couldn't take any appointments for six months and the doctors there called Luhan at St. Joseph's Hospital and talked to him personally and set up a 5:00 o'clock appointment that night with Luhan.

I didn't go to the hospital—you know, where I was supposed to go, and I didn't tell my husband that I wasn't going to the hospital, but I called him when my sister was taking me to Dr. Luhan's office so he wouldn't go to the other hospital expecting me there.

Q. You've described several operations that you had from Dr. Amar and the condition, how your condition changed over that period of time. What was Dr. Amar telling you throughout this period when you had these surgeries from him?

A. He kept telling me not to worry, everything was
[6719] going to be fine. And he kept referring back to Lipton when I tried to ask him questions of what was happening, why it was happening.

Q. When you say he referred to Lipton what do you mean?

A. He kept saying it was Lipton's fault, that he messed up during the first surgery, although during the fifth surgery that Amar did on me, instead of cutting me underneath the breast, I was cut down in the middle of my ribcage, where I have scars going from underneath my arm around on both sides and down on the ribcage, too, where he had cut, because he said he was making the pocket different and that way where the weak skin was it wouldn't break through anymore, which at that time sounded sensible, I guess, although it still—even though he went down and cut he didn't close up the other opening. He just went down and he cut below it and left it open.

Q. You mentioned that you went to Los Alamitos Hospital and they referred to a Dr. Luhan. What has been your experience with Dr. Luhan?

A. He's fantastic. First of all, he told me when I first seen him, he had taken all kinds of photographs
[6720] and he said that I did have gangrene. And he said the reason that Amar did the surgery on the left breast was because he had messed the right side up so much, he said, it's like if you make a blouse and you get one sleeve too short, he says, you've got to cut the other sleeve to make it the same length.

He put me in the hospital and they took out the implant. He worked on the area to get the gangrene and stuff out and cut the dead tissue and stuff away. He's just been really good. He'll sit and he'll explain step by

step what he's doing, why he's doing it, why it needs to be done.

He was going to do surgery on me again in May.

Q. May of '77?

A. June 20, I was supposed to go in the hospital. He was going to put small implants in, but he decided then that my nerves were still too bad because I was still having nightmares, still waking up screaming and everything, so he postponed it until October, which at that time he did put in small implants, but I have an awful lot of scar tissue in the left side, which is a very hard area. The implant is soft, itself, but the scar tissue in different areas is very bad. I still have a
[6721] very deep, deep scar on the right side, which after my nerves and things get calmed down, and if I can ever get back to normal, and if I want to, then he can take and do plastic surgery by skin grafts from my legs and cover up the area, it's about a two-inch area that needs to be filled.

When I first went in for the surgery I was wearing a B bra, and now I can't even wear an A, so instead of improving myself, I made it worse.

JUDGE BARNES: How much money did all of this cost?

THE WITNESS: So far, it's a little better than $20,000 in medical bills.

By Mr. Bierig:

Q. On the basis of the experiences that you've just described, what do you think the local Medical Society should do about advertisements such as the one I showed you earlier?

A. I really don't believe they should be allowed to advertise, for the simple reason, like someone like me

who has been a joke for the last five years and all of a sudden you see an ad in the paper, well, all of a sudden something can be done. You never think of asking your own doctor about it, and all of a sudden there's an ad, and you're going to follow an ad. We went to
[6722] Women's Advisory Council and got nothing but a run-around, doctors that wasn't qualified. I found out that Amar and Sharber were supposed to have been plastic surgeons—they're not; one is an ear, nose and throat specialist; Sharber, we don't know what he is. He was supposed to have been Chief on Staff of Plastic Surgery at Martin Luther King and he wasn't even on staff there, because my husband tried to get ahold of him one night when I was having a very bad night.

I don't think they should be allowed. I really don't. Because, I know without the ad I never would have went ahead with it.

MR. BIERIG: We have no further questions of the witness, Your Honor.

MS. MALESTER: Your Honor, we have no questions of this witness.

JUDGE BARNES: Thank you very much.

MR. BIERIG: May we take a short recess, Your Honor?

JUDGE BARNES: We'll take a 10 minute recess.

Testimony of AMA Consumer Witness # 3 (Tr. 6794—6820)

[6794] PROCEEDINGS

JUDGE BARNES: On the record.

MR. BIERIG: Good morning, Your Honor.

Before calling our witness this morning, we would offer in camera Respondent's Exhibit 880, which is a description of the identity and address and occupation of our first witness this morning.

JUDGE BARNES: You offer it in camera?

MR. BIERIG: Yes, Your Honor.

JUDGE BARNES: I'll receive Respondent's Exhibit 880 and this is an identification of our witness No. 3 and the first witness this morning. I'll receive RX-880 in camera.

(The document referred to, heretofore marked for identication Respondent's Exhibit No. 880, was received in evidence in camera.)

WITNESS NO. 3 was thereupon called as a witness for the Respondent, and, having been first duly sworn, testified as follows:

Direct Examination

By Mr. Bierig:

Q. Have you ever undergone cosmetic surgery?

A. Yes, I did.

Q. For what purpose?

[6795] A. Breast augmentation.

Q. How many operations have you had for that purpose?

A. I have five within a six-month period by the doctor who was supposed to perform the operation, and then I had one a couple of months later by another doctor to get out of the whole problem that developed.

Q. Who was the physician who performed the first five operations?

A. Dr. LeRoy Amar.

Q. And who was the physician who performed the final operation?

A. Dr. A. Richard Grossman.

Q. When was your first operation?

A. The first week in September of '74.

Q. Where were you employed at the time?

A. I was working for a secretarial service on Wilshire Boulevard.

Q. How did you decide to have comestic surgery?

A. Well, I had considered it before on and off, one hears about things. Also I had seen advertisements in the newspaper and I had been hearing things at that time over the radio about women who help women, an organization that's supposed to be concerned about women's rights and how women can cope with the ongoing world today. And also Women Who Help
[6796] Women happened to be situated next door to the office where I was working.

Q. Could you describe, if you recall, the advertisements that you saw in the newspapers and printed media?

A. Yes, I have some copies that I took from my lawyer.

MR. BIERIG: Your Honor, we just received these. Perhaps the witness could use these to refresh her memory.

JUDGE BARNES: No problem in receiving them in evidence, is there?

MR. COSTILO: We don't object. In fact, rather than have testimony as to an exhibit where we have the ad, I think we should have the ad.

JUDGE BARNES: She can identify them.

MR. COSTILO: Yes.

MR. BIERIG: I don't have copies to show you since I just received it.

I'm going to show you now four copies of printed advertisements. Perhaps these can be identified, Your Honor, and marked into evidence at a later time. But perhaps the witness can just identify them now and then we'll assign them numbers.

By Mr. Bierig:

[6797] Q. I ask you whether you can identify these.

A. These are the ones that I have been keeping with me that I clipped, yes.

Q. Now, are these advertisements that you had seen prior—

A. (Interposing) Yes, very similar ones. I'm sure that a couple of them are exactly the same, yes.

Q. And could you just give the dates of the four?

A. That are in here?

Q. Yes.

A. This is February '76, one is July '76, one was about June '75, and one was Cosmopolitan Magazine, it's '73 copyright.

MR. COSTILO: Your Honor, I was unclear when we were talking about the ads here. I was under the impression that the witness was going to identify ads which she saw which led her, particular ads which led her. I think these are after her operation.

THE WITNESS: These are ones that I clipped afterwards that are the same as the ads I saw. Of course you don't clip them before and save them. My

lawyer said, "Have you seen them recently?" I said, "Yes." So I cut them out for her.

[6798] JUDGE BARNES: These are identical?

THE WITNESS: Oh, yes, a couple of them I'm positive are the same things.

MR. COSTILO: As long as we have that clear.

JUDGE BARNES: I think the record is clear.

MR. BIERIG: I think perhaps we can label these Respondent's Exhibits 690, 691, 692 and 693 when we offer them.

By Mr. Bierig

Q. Could you describe the radio commercials that you heard at this time?

A. Yes, they sounded very personal and very concerned with women. I was very taken by them. They have a woman in a soft spoken voice who says, "Today's world is a lot to cope with. Come in, we'll talk to you, we'll counsel you. We've got counselors who will help you solve your problems, whatever they might be, mental, physical, whatever." It was a very personal oriented advertisement.

Q. What influence, if any, did these commercials have on getting you to have cosmetic surgery?

A. They had a lot of influence, besides the fact that I'd also seen it in the paper. But the commercials were running quite often on the radio and, of course,
[6799] being familiar with the organization next door, I was very impressed with the whole thing.

JUDGE BARNES: These radio ads were sponsored by?

THE WITNESS: Women Who Help Women.

By Mr. Bierig:

Q. Did you think that the commercials or the print advertisements were approved in any way?

A. As just a lay person, I would have assumed so, yes. One knows that you can't false advertise. There's supposed to be laws against this type of thing. So you hear it over the radio or you see it in print, it should be the truth, especially when it concerns a doctor I always thought.

Q. After hearing these commercials, what were your expectations about Women Who Help Women and after seeing the printed advertisements?

A. Well, that I would go in and I would be treated as a person with problems that could be solved with the help of other women. That I would be treated in a concerned manner, considerate manner.

Q. In fact, what was your experience with Women Who Help Women?

A. I was very disappointed with the organization itself. I went in and there was some big man who
[6800] sat behind a desk with a cigar. He wanted to know when you could have whatever it was you wanted done and they'd do it for you. I was very disappointed with the way the organization was run, very much so.

Q. What were the main concerns of Women Who Help Women?

A. Well, according to the advertisements, to help you figure out your problems and what would be right for you.

Q. What were the concerns in reality?

A. How much money you had to spend and when and whatever you wanted done, they could work out for you. That's what they told you.

Q. What kind of sales techniques did they use?

A. What do you mean, sales techniques? On me?

Q. Yes.

Was there any pressure or what kind of—

A. (Interposing) Of course there was from the doctor because he said he was going to give me a special rate because I knew somebody else. He said if I brought in $750 cash and if I came in within the next few days, he could give me a special rate and a special deal. It would be cheaper and everything else. So that very much influenced me, yes.

Q. When you say "the doctor", was this Dr. Amar?

[6801] A. Yes, LeRoy Amar.

Q. Prior to the surgery, did you ask Dr. Amar any questions?

A. Yes, when I went into his clinic in Stanton, I went in for an interview there with him. Of course he was three hours late, and I was very nervous. I sat down and wrote down questions I wanted to ask him. I went in and he said, "What do you want?" And I told him. He didn't seem to volunteer any information. So I said, "I have a list of questions. Let me read them to you." And I did. I asked him questions but he didn't volunteer any information. His answers were curt, very curt.

Q. Could you, if you recall, list some of the questions that you asked and the doctor's response to these questions?

A. All right. I asked, you know, what would, would there be any problems and he touched me a little bit and said, "No, you're quite fleshy, there shouldn't be any problems." I said, "What about nursing children? He said there shouldn't be any problem. I said, "How about the sensitivity of the breast and everything, will there be any physical change?" He said, "The nipples may be sensitive for a short while but otherwise it's

[6802] all psychological anyway." I remember I was very

flabbergasted by that type of thing. It didn't seem to fit my question.

I asked how long the period would be for healing and all that. He said it should be completely healed in two years. I would never know that I had ever had an operation, those type of questions. He really led me to believing absolutely no problem whatsoever, done every day.

Q. Did you ask whether he was Board certified?

A. Board certified. No, I wouldn't think to ask a doctor if he was Board certified.

Q. Do you know what Board certified means?

A. No, I have no idea.

JUDGE BARNES: Where is Stanton?

THE WITNESS: In Orange County. He had his clinic there before he moved it up to Wilshire.

By Mr. Bierig:

Q. What were you told by Dr. Amar regarding the difficulty of the operation?

A. He told me that it would be a simple operation, just make a little incision and insert. There shouldn't be any problem. That as long as I followed his instructions as far as reaching or running or jumping or anything strenuous for a couple of weeks that there wouldn't be any problem.

[6803] Q. What were you told about possible scarring as a result of the operation?

A. That there should be about a two-inch scar under each breast and they shouldn't show.

Q. In fact, what kind of scars, if any, were there?

A. Well, scarring was very, very bad. I've since had plastic surgery to remove the scars. And it has

somewhat impaired the use of my left arm because there's so much scar tissue inside.

Q. When you say very, very bad, what do you mean?

A. He had inserted drains and all kinds of things. Dr .Grossman has pictures of them, huge, huge scars and, of course, they go all the way around.

Q. What did Dr. Amar tell you, if anything, regarding the amount of time it would take before you could go back to work?

A. He said in a couple of weeks I could go back to work as long as I didn't reach over filing cabinets and stretch and all.

Q. In fact, how long was it before you were able to go back to work?

A. It was more than six months before I could work.

Q. What, if anything, did Dr. Amar tell you about his training and qualifications?

A. It's funny because he picked me up because I
[6804] didn't have transportation, he took me to the operation. And on the way I did talk with him some and he said he was schooled in plastic surgery in South America, which, of course, later I found out he had been there once and met a man and talked with him for a few hours. That was his schooling in South America. He said he had been all around the United States, which, of course, later I found out he had been delicensed from all these states. He said he schooled in New York, which I suppose he did school at Columbia. It all sounded very impressive the way that he gave it to me at the time.

Q. What, if anything, did Dr. Amar tell you about complications that could occur from your surgery?

A. He didn't inform me of any complications that could occur. I guess I was very naive about it. I had never had surgery before. I had never really had a doctor I could discuss things with before. When he said no problem, I assumed there was no problem.

Q. You mentioned that Dr. Amar didn't give you satisfactory answers to the questions that you asked. Why, in that case, did you allow him to operate on you?

A. Well, number one, at the time I didn't realize
[6805] that they weren't satisfactory answers. I asked a question and I got a two-word answer. Maybe that's all there was. I know now that they weren't satisfactory answers.

Also I felt very pressured by the fact that he wanted me to do it right away. I've forgotten the question. I'm sorry. Oh, why did I go ahead and do it. Right. He told me that if I brought in the money and if I came in within the next few days, he could do it for me at a special rate. That very much impressed me at the time. I didn't have any money to speak of.

Q. What effect did the special rate have on your decision?

A. A lot of weight.

Q. Incidentally, how did you pay for this operation?

A. I brought in $750 in cash.

MR. BIERIG: Could I be excused for one second?

JUDGE BARNES: Yes.

By Mr. Bierig:

Q. When was the first operation?

A. First week in September of '74.

Q. Could you describe the conditions at the clinic
[6806] where the surgery was performed?

A. Yes, I was appalled when I went in there. I didn't believe they did surgery there. In fact, I don't think I really believed that was where they did the surgery. I thought it was just where you interviewed. It was very, very dirty and the halls were dark. You could hear women crying and everything. Doors were open. I understand they were giving abortions, that he gave a lot of abortions there.

As I said, I waited three hours for the man to appear. Everybody else was very nervous. I was appalled. It was not a very clean place for a clinic.

Q. Why did you allow yourself to be operated on in a clinic like that?

A. That's where he did it. The operating room was a little more sterile. As I said, I guess I'm very naive. I didn't know much about things like that.

JUDGE BARNES: When did you pay your money, before the operation?

THE WITNESS: Yes, just before.

JUDGE BARNES: Who did you give the money to?

THE WITNESS: His nurse.

[6807] *By Mr. Bierig:*

Q. How long did you remain in the clinic?

A. I believe I was there all day because the doctor picked me up and took me home when he was done and my boyfriend picked me up after work, he dropped me off. So it must have been a good eight hours.

Q. What was your condition on leaving the clinic?

A. I must have been out. I really don't know what happened to me from the time I went in until I found

myself throwing up in the doctor's car. He was very upset with me. That was just before he dropped me off. It must have been around 4 o'clock in the afternoon.

Q. What happened then?

A. My boy friend picked me up at the office and took me home and put me to bed and started giving me the drugs that the doctor had given him, had given him prescriptions for and I slept.

Q. You mentioned the drugs. What sort of drugs did Dr. Amar prescribed for you?

A. I think there was tetracycline, Nembutal, codeine and some kind of overin or something, I'm not sure of the other one, some kind of female drug I understand.

Q. For how long did you continue taking drugs of
[6808] the prescription of Dr. Amar?

A. All the time that I knew Amar, he just kept refilling them.

Q. For how long a period of time was that?

A. Over six months.

Q. What effect, if any, did these drugs have on you?

A. It seemed like the six-month period just went by and I didn't know what happened. I wasn't very cognizant most of the time. I had to keep taking sleeping pills morning, noon and night and I had to take the codeine constantly. I felt that I had to keep taking them. There was a lot of pain, a lot of pain.

Q. What happened to you after you got home after having the operation?

A. After the first operation. I slept and my boy friend and my next-door neighbor was a nurse, and between the two of them, they fed me and took care of me, bathed me and all that. I couldn't get up. I couldn't move, couldn't do anything. There was excrutiating pain. The bandages were so terribly tight that finally one day I couldn't stand it any longer, I started screaming, and the nurse unwrapped me and—

[6809] Q. (Interposing) This was your next-door neighbor?

A. Yes.

And she found these huge discolorations all over the left side of my body. It was very, very swollen. I was really swollen.

Q. How often during this period of time did you see Dr. Amar?

A. He had told me to come in, it was something like four or five days. So it was just about that time to go in to see him when she discovered this.

Q. So for the four days after the operation, how often did you see Dr. Amar?

A. For those four days, I was just in bed. I didn't see anybody.

Q. You mentioned you discovered this discoloration and you had the pain that you described.

A. Excruciating pain.

She got on the phone immediately and called him and said, "Something must be done. This girl has got these hematomas all over her body." It was blood clots I understand. So they said to bring me right in and she did. She threw me in the car and took me down there and they operated.

Q. What was your condition after that operation?

A. She was in the operating room with me. She [6810] said that they removed the blood clots. It took two doctors to remove the blood clots. He had to call in another doctor.

Q. Do you know who the other doctor was?

A. A Dr. Brown.

Q. Would this be John Brown?

A. I believe that's the name.

And they removed the blood clots and she took me home. Throughout this whole thing, I was very upset

by the fact that I had wanted two inches added to my bust line and, of course, I was out to here.

Q. When you say "out to here"—

A. (Interposing) I was really swollen and I was wrapped up.

So after the second operation, I started talking to the doctor on the phone about it. I kept saying, "Why is it so big? It's not supposed to be like this." He said, "Well, you're swollen. You'll like it. Trust me, you'll like it, whatever happens." My mental stability and all and as foggy as I was, I just trusted him for a while.

Q. Could you describe the subsequent operations that you had and the reasons for having them?

A. Well, they were very swollen and very big and
[6811] I was very unhappy.

Q. Your breasts?

A. Right.

So he said we could make them smaller, which was what I wanted in the first place. Also one of them got very, very hard and one of them dropped very low to my chest. So he said, "Well, this happens sometimes. Come in, we'll fix it, put in smaller implants. I'll raise one, I'll clean one", whatever it is that they do. So I went in for a third and a fourth operation. Both times the same problem. Both times he kept putting in either the same kind of implant or larger implants. Because as I found out later, he told my boy friend one time that that was all that he had in the office at that time.

My boy friend was screaming at him, "Why did you operate on her if that's all you had and you knew she wanted smaller?" He said it had to be cleaned and had to be done, she'll like it. He kept saying, "She'll like it." This is his idea of a woman, I guess.

I kept going back and he had to keep cleaning the capsules, releasing the capsules, I guess it is. The one kept falling and he kept hiking it up which is why I have so much scar tissue

[6813] Q. Did you subsequently have any other operations from Dr. Amar?

A. Yes, foolishly enough, after that, well, I had to go back because of the drains and everything and he had promised me that he would put in the small, tiny implants for me. So I went in for one last operation and I was asleep for that one. I got an anesthesiologist because I wasn't about to go through that again. I paid an extra $50 for it and this guy came with his son, some ten-year old kid stood through the whole thing which is another amazing aspect of it. He put me out.

I was home when I woke up. My boy friend was there and he was crying. He was very upset. I come to find out that the doctor had not only taken out the implants but he put in larger ones. He had put in round ones which I've since come to find out from my other plastic surgeon, I should never have had, huge round implants. They were gigantic. And Amar had told my boy friend that he put those in because that's all he had at the time. They were special. He was saving them for his girl friend. My boy friend was just beside himself. That was just about the end of my string, too.

Q. What was your physical condition at this time?

[6814] A. Physical condition? Physical, a lot of pain, a lot of agony, a lot of mental anguish. I didn't know how I could go through any more of it.

Q. What was your emotional condition?

A. That was it. I just didn't think I could cope with it any longer.

Q. What do you mean by that?

A. I couldn't see how I could go on with this. It was a nightmare for about six months. It just got worse and worse and worse. This was like the end, just about the end.

I went in to see the doctor one more time after this. It was a few days later. I had several people staying with me. They were afraid to leave me alone, my friends. I went in one more time to see the doctor and I said, I confronted him, I said, "Look what you've done to me. How could you do this? I'm deformed." I really was. It was just really awful. He sat there and he looked at me. He said, "I have one more thing. Maybe if we take off your nipples and we put them in different spots on your breasts." I just freaked out. This guy was sick. I told him, I said, "You're a sick man", and I ran out. That's the last I saw of him.

Q. Did you then find another physician?

[6815] A. Yes, I did right away.

Q. And this was Dr. Grossman?

A. Yes.

Q. How did you find Dr. Grossman?

A. I had a friend who worked with patients who needed reconstructive surgery and plastic surgeons. I called him and asked him to recommend somebody and he recommended Dr. A. Richard Grossman who was the head of the Burn Center in Sherman Oaks and he's a reconstructive surgeon and I needed reconstruction. So I went to him.

Q. And did you see Dr. Grossman?

A. Yes, he was appalled. He was appalled that this could have happened. He was the one who recommended that I sue the doctor and report it to the AMA and the Medical Board. Whatever went on from there, he was the one that began the whole thing.

Q. What was your experience with Dr. Grossman?

A. He said I had to wait a few months. He wasn't going to operate that soon. He said nobody had any business going through this operation month after month like Amar had. He said I had to rest. I had to recuperate. He wanted to wait but I couldn't live like that. We waited until July and finally he did operate and he removed the implants.

[6816] JUDGE BARNES: July of '75?

THE WITNESS: Yes.

A. He removed the implants. He kept them. He showed me the size I should have had and the size I did have. He took pictures of the damage that had been done. He had pins stuck in me. He took pictures of the scars and everything to use. He was very good. He took off the scar tissue and did the best he could. I'm very fortunate I understand.

Q. When you say you're very fortunate, what do you mean?

A. Well, I consider myself very fortunate that I'm back to looking almost like I did before. I mean at least I'm normal looking.

JUDGE BARNES: What kind of scars do you have at present?

THE WITNESS: Well, one breast I lost a lot of tissue on and it's very hiked up and pinched up underneath. The other one is just a very long scar.

By Mr. Bierig:

Q. What effect did all the surgery that you've had have on you physically?

A. Physically?

Q. Yes.

[6817] A. I'm a very nervous person as you can see.

Q. What effect did it have on the feeling in your breast?

A. It's been three years now and I still have no feeling in my breasts whatsoever and I'm a young woman and that's very hard to take. There's great sensitivity in the nipples. It's hard to even wear a bra. Also, as I think I mentioned before, my left arm is impaired as far as throwing back over my head, playing tennis and all of that. I can't because of the pinched condition of my breast.

Q. What ffect, if any, did this surgery have on you emotionally and psychologically?

A. Emotionally, it will always have an effect on me emotionally. As far as trusting male doctors, that's done a trick on me, too. I just have female doctors now. They understand the consequences of what they're going to tell you, how you're going to feel and all of this. Also, if I were ever to see a doctor again and he were to tell me something bad, I would probably get two or three other opinions for sure.

Q. What effect, if any, did this surgery have on your employment?

A. I was unemployed for a long period of time. I
[6818] borrowed a lot of money. I couldn't work. Is that what you mean?

Q. Yes.

JUDGE BARNES: How much money did you pay Dr. Amar?

THE WITNESS: I paid him $750 in cash for the first operation and then $50 in cash for the anesthesiologist on the last one.

JUDGE BARNES: How much for Dr. Grossman?

THE WITNESS: $500 for him and I was in the hospital. He was very, very good to me. That was just the hospital fees and I was overnight and all that.

By Mr. Bierig:

Q. Do you know whether Dr. Grossman charged you for the operation he performed?

A. I don't believe so. I think, if I remember correctly, he said this is for staff, for anesthesiologist, hospital care. He wanted to see this man out, too.

Q. You may have answered this to some extent already but how did your experiences influence your perception of doctors?

A. Well, it's funny because I, and I assume a lot of other people, always kind of not idolized doctors
[6819] but assumed that they had gone through their schooling and they knew what they were talking about. They stick a knife into somebody and they cut them open, and you trust them with lives, human lives. I thought doctors were great people. But they've got a lot of quacks running around with licenses that's cutting people up and I have been through it, I know about it. Especially, I suppose this is very opinionated, but especially male doctors, I see them now as very unfeeling people. I won't communicate with them any more.

Q. What effect, if any, have your experiences had on your perception of whether or not ever to have surgery?

A. Well, I told my female gynecologist, I said, "Don't ever bother to tell me I need surgery because I won't."

Q. You won't what?

A. I won't have surgery. I'm never going under the knife again. I'll die with it.

Q. On the basis of your experiences, what do you think that medical society should do, if anything, about the kind of advertising that you saw in print and in radio?

A. I can't believe that there is a medical society [6820] if they're not controlling these doctors. Doctors are supposed to be licensed and they're responsible for human lives like I said. What good is the AMA? I thought the AMA was responsible for this.

MR. COSTILO: Your Honor, on this last line of questioning here, I think that a foundation has to be laid that this man was in the medical society and would have been subject.

JUDGE BARNES: You can ask that on cross-examination. She's giving her personal opinion.

MR. BIERIG: We have no further questions, Your Honor.

JUDGE BARNES: I want to ask you, if you go back now to the time before you had your first surgery, was this your idea or your boy friend's idea?

THE WITNESS: Of the surgery? Oh, he tried to talk me out of it all the way through. It was my idea. I heard that it could be done. I figured it would help me cope with the world better so I did it on my own. It was my mistake.

Testimony of AMA Consumer Witness # 5 (Tr. 6854—6871)

[6854] MR. YOULE: Your Honor, we would like to submit at this time Respondent's Exhibit 882 in camera which is an identification of the next witness who will be referred to as witness No. 5.

JUDGE BARNES: I'll receive Respondent's Exhibit 882 in camera. It identifies our witness No. 5 who is our third witness for today.

(The document referred to was marked Respondent's Exhibit No. 882 for identification and was received in evidence in camera.)

WITNESS NUMBER 5 was thereupon called as a witness for the Respondent and, having been first duly sworn, testified as follows:

Direct Examination

By Mr. Youle:

Q. Have you ever had any experience with plastic or cosmetic surgery?

A. Yes, when my daughter was sick, when my daughter had it and I took care of her.

[6855] Q. What type of a surgical technique did your daughter undergo?

A. I don't know what the terms are, but she said it was a tummy tuck.

Q. Was that a procedure having to do with weight reduction in some way?

A. Right.

Q. When was the first time that you learned that your daughter was interested in undergoing cosmetic surgery?

A. She came home excited. This was in November of 1976, and she had an ad that she had gotten from

a friend but she had to return it. So she went out to look for a San Jose Mercury to get the ad so she could show it to me. I really didn't want to see it because I didn't want her to have this but she insisted. She was over 21 so I couldn't do anything about that. So she went out and got the ad and brought it back to me.

Q. And when she brought it back to you, she showed you this advertisement?

A. Yes, she did.

Q. Do you recall basically what was included in the ad?

A. I brought the ad here.

[6856] Q. I'm handing you a document which has been marked for identification as Respondent's Exhibit 687 and ask you whether you can identify that.

A. Yes.

Q. And specifically in the lower right-hand corner of that exhibit, is this the ad that you spoke about?

A. Yes, it is.

Q. Now, I note that this particular exhibit appears to be from a San Jose newspaper dated November 3, 1976. Was that the same day that your daughter returned with the advertisement?

A. No, it wasn't.

Q. When was it that she showed you the ad?

A. It was around, I would say around the 20th.

Q. But was the ad that she showed you similar to that one?

A. Right, it was the same ad.

MR. YOULE: Your Honor, we offer Respondent's Exhibit 687.

JUDGE BARNES: Any objection?

MS. MALESTER: No objection, Your Honor.

JUDGE BARNES: I will receive Respondent's Exhibit 687.

(The document referred to was marked Respondent's Exhibit No. 687 for indentification and
[6857] was received in evidence.)

By Mr. Youle:

Q. What was your response when your daughter showed you this advertisement?

A. Well, I really didn't like it because I felt that she should just go on a diet and that was it, but she couldn't see it that way. She said, "This is something quick. You won't have to wait and I'm going to call and see about it." So she did. She called the San Jose office and right away they told her to come in.

Q. When exactly did she call the office of this clinic?

A. Oh, it was in November, the 20th, the same day that she brought the ad in.

Q. Did you speak with her after she consulted these people on the phone?

A. Yes, I did. She said, "There's nothing to it. The government will have a lot to do with it and it's something that's very safe. They assure me that it's safe and it won't take long. They'll just pull off the fat and give me a new belly button and then I'll be in good shape which will only take a couple of weeks."

Q. Did your daughter consult your family physician
[6858] about this advertisement?

A. No, she didn't. I tried to get her to do this. She said, "Oh, it's safe. They showed me pictures of what would happen, that it's safe."

Q. When you say they showed her pictures, is this after she went into the clinic?

A. When she went to the office to make the arrangements to go into the hospital for the surgery.

Q. What happened when your daughter went into the clinic for her first visit?

A. For her first visit. You mean after the operation?

Q. No, prior to that.

A. She just come back with, she was all beaming and she needed $260 to make out enough for the down payment.

Q. And where did she propose to get this money?

A. Well, she asked me if I would let her have it and she would get it from her boy friend and pay me back.

Q. Had your daughter, previous to showing you this ad, had she been involved in any other types of weight control?

A. No, not other than what the doctor had told her to get on a diet because she was a diabetic and [6859] we were on this diet together she and I.

Q. When you referred to the doctor that told her that, which doctor was that?

A. It was Dr. Register.

Q. Is this your family physician?

A. No, he was her doctor.

Q. I see.

And this physician was not connected with the clinic?

A. No, he wasn't.

Q. At some point did your daughter happen to go into the clinic for cosmetic surgery?

A. Yes, she went in, and that's when they made all the arrangements and showed her pictures, what type of operation she'd be having because she was very excited about it and she come and told me that I wouldn't have anything to worry about, that this operation would turn out fine. And I asked her had she

told them that she was a diabetic and she said, yes, she had told them and she also told them that she had a hernia. The doctor said, "Don't worry." While he was inside, he would take care of everything for her.

Q. Sometime prior to your daughter's surgery, did you have occasion to call up the clinic?

[6860] A. Yes, I did.

Q. Can you describe why you called the clinic?

A. Well, I was concerned because her being a diabetic and I had a little experience, I was a cook in a hospital and I had five diabetic patents, and I know that any time if they got just a scratch that they wouldn't heal up. And this is what I was afraid of. So that's why I called the clinic.

I didn't get a chance to speak to her doctor. I guess it was a receptionist. I explained it to her. She said, "Well, your daughter is over 21 and she knows what she wants to do."

Q. When did your daughter go into the clinic for the surgery?

A. She went in, I think it was a Tuesday, they operated the next day which was Wednesday.

Q. And this was towards the end of November of 1976?

A. This was before Thanksgiving, the day before Thanksgiving.

Q. And that would be in 1976?

A. '76.

Q. How long was your daughter in the clinic?

A. After the operation?

Q. Yes.

[6861] A. Maybe three or four days.

Q. And then where did she return to convalesce?

A. She came to my house. She said, "Maybe I should stay here with you until I feel up to going back

to my apartment." I told her it was quite all right. I had plenty of room for her to stay so I could take care of her.

Q. Do you know how much money your daughter paid for her cosmetic surgery?

A. I would say so far, I would say over $5,000.

Q. And when your daughter returned to convalesce in your home, can you describe for the Court her physical state?

A. Yes, she was, well, she had had her hopes up high. She felt that everything was going to be all right. But there was no clamps or she wasn't sewed up and the incision was all across the stomach, all the way across, and it must have been an inch and a half wide and you could see everything in this incision.

Q. Was your daughter in pain during this time?

A. Yes, but she told me that she was feeling all right. She said, "I'll be all right." But I knew that she should have even had clamps or something across this place because it kept weeping.

[6862] Q. What do you mean by weeping?

A. It was just running and I had to buy the four by twelve gauze that long (indicating) to put on it. I had to use five each time. This must have been about eight times a day not including the nights that they would soak.

Q. How long was your daughter convalescing in your home after the surgery?

A. From the time she come out of the clinic until I had to put her in El Camino Hospital, which was the latter part of January, around the 26th of January.

Q. And that would be of 1977?

A. Right.

Q. At some point did you become concerned about your daughter's physical condition?

A. Of course, yes, definitely. I was concerned about it and I went and talked to Dr. Rundles about it.

Q. Dr. Rundles is who?

A. The doctor that did the surgery.

Q. How long after your daughter's surgery did you first contact Dr. Rundles?

A. Oh, about two days afterwards.

Q. Can you describe what essentially you said to
[6863] Dr. Rundles?

A. Yes, I asked him why she didn't have clamps. The place was open all the way across and it was weeping and I wanted to know how come it wasn't sewed up until at least it healed some. And he said, "Oh, we don't do that. You don't worry about that. You have nothing to worry about. In a few days, she'll be good as new."

Q. In a few days, was she as good as new?

A. No, she wasn't.

Q. When did you next contact Dr. Rundles?

A. Well, I contacted him maybe about three days later after I had talked to him again, and I told him she was in pain and the place was constantly weeping and it cost around $15 or $20 every time I went to El Camino to get those bandages and I had to get lots of them. My money was running out. I wanted to know how long would she have to lay like this open like that.

He said, "You bring her here because I can't go there. It's too inconvenient for me." I said, "It will be a little inconvenient for me to get an ambulance and bring her", because with her open like that, she couldn't ride a bus and I would be afraid for her to take the car.

[6864] Q. Did your daughter ultimately go into the clinic to see Dr. Rundles?

A. Yes, some friends, the Swets, who liked in Grass Valley came down with a camper and put her in the back of the camper and took her to Dr. Rundles. I went with her.

Q. Will you describe what happened when you visited Dr. Rundles at this clinic?

A. Yes, my daughter introduced me to him. And he said, "Oh, yes, I spoke to you on the phone about her condition." He said, "Don't worry, she's going to be all right." I said, "I do worry." He said, "Well, we'll go in and take a look at it." He took her in and he said, "I want you to stay outside." I said, "No, this trip I'm going in. I want to see what you're doing. Maybe it's something that I'm not doing right. I want to see how you do it." So he said, "O.K."

And I went in. He took one piece of cotton and he put it in the peroxide, bottle of peroxide, and then he cleaned the whole area with that one piece of cotton. Then he threw it in the trash. And I asked him, wasn't he supposed to do that with more than one piece of cotton? And he said, "No, no, it don't make any differ-
[6865] ence. It's O.K." Then he got a thing like a paddle and put it in a big jar of salve, yellow salve, and put it all across her stomach in that inch and a half wide incision and covered it up all the way with the salve, gobs of it in there, and then he put the padding back on there and then put her in this girdle thing and zipped her up.

Q. Did he give you any instructions as to what type of care you should be giving her?

A. No, he said, "That's all you do, spread lots of salve on there."

Q. When you returned home after this trip to the clinic, had your daughter's physical condition improved?

A. No, it hadn't.

Q. Can you describe for the Court what happened after you returned?

A. Well, she was in pain, she was in great pain. I said, "Maybe we can get some pain pills." He didn't give me any pain pills that trip. I called him back and talked to the receptionist. She said she would ask him if she could have some pain pills. She asked him and he said, yes, she could have pain pills. But he didn't want to give her too many pain pills. I said, "That's O.K." I gave him the M & M Drugstore's number and [6866] he prescribed pills for about three or four days.

Q. Subsequent to taking these pills, did your daughter's condition improve?

A. No, it didn't. She slept a little bit but that is all.

Q. During the entire period of convalescence, did you ever consider consulting another physician for his opinion?

A. Yes, I did. I talked to my daughter about it. I said, "Why don't we talk to Dr. Register or some of the other doctors. Let me call somebody to come in." She said, "Momma, it's nothing to worry about. I'm O.K." She said, "Dr. Rundles said that it just takes a little bit longer for some people." So I said to her, "Like you, you're a diabetic?" She said, "Don't worry about it. He told me that it's going to be O.K." She said, "I'm getting better. I guess I'm over anxious to heal up."

Q. After your one trip to Dr. Rundles and your phone call about pain pills, did you ever call him again?

A. Yes, I did. I called him again and I asked him if he would put, she was going to come in that Monday, and if he would put a few clamps in there to clamp that place up. I said, "I have to look in it every day

[6867] and it just don't look quite right. I feel her not being in the hospital, it's not going to be very good for that place to stand open like that." He said, "All you have to do is keep putting the gauze on there. You keep her bandaged up and keep plenty of salve on there. You just worry too much so you cut it out."

Q. And did Dr. Rundles come down?

A. No, he didn't. He said he couldn't come down. We would always have to take her to Oakland. He moved his office to San Francisco and then we had to go to San Francisco.

Q. After this phone call that you just described, did your daughter's condition improve after that?

A. No, it didn't. It stayed the same and then it began to get worse.

Q. Will you describe how it became worse?

A. When she complained and told me that she think, she said, "Well, Momma, I think I made a mistake."

Q. At some point did you take your daughter to an emergency room of a hospital?

A. Yes.

Q. Can you describe how that happened to come about?

[6868] A. Yes, she said that she had made a mistake and she would like for me to take her to the hospital right away. So I called Dr. Rundles and asked for medication and he said that he was busy, to take her to the nearest emergency room. So then I took her to El Camino Hospital because he said he wouldn't write a prescription, wouldn't O.K. the prescription for antibiotics, and that I should just take her to the nearest emergency room, so I did.

Q. Can you describe for the Court what happened then?

A. Yes, I took her and I called Dr. Register. He said he would meet me there but he didn't come and another doctor, Dr. Watson, came in and looked at her and he said, "I'm going to have to move her to intensive care right away." He said, "You keep your fingers crossed that we can save her."

Q. How long was your daughter in intensive care?

A. About three days.

Q. And was this up until her death?

A. Yes.

Q. At the time your daughter underwent the surgery, was she working?

A. No, she had to quit work because the doctor told her that she was overweight and that she needed
[6869] to lose some weight and that she was a diabetic.

Q. Did she have any children?

A. Yes, she had one, a boy.

Q. And was she supporting her boy?

A. Yes.

Q. Are you currently supporting your grandson?

A. Yes, I have been.

Q. What's been the total cost of medical care that you and your daughter have expended in connection with the whole cosmetic surgery process?

A. It's been quite a bit. I don't want to say exactly how much, but I do have receipts where I can figure it up and get the real cost. I just haven't been up to it.

Q. I understand.

Can you describe for the Court what effect this whole ordeal has had upon your life?

A. Well, I had a heart attack.

Q. Are you currently working now?

A. No.

Q. What would you like to see medical societies do?

A. I tell you what I really would like to see them do

is get rid of those ads in the paper because I feel that if my daughter hadn't ever seen that ad, she got so excited about the ad and she was just, I couldn't tell
[6870] her anything. She had to go and do it because they told her it would be O.K. The doctor reassured her that she would come out of it just fine and she would be streamlined.

MR. YOULE: I have no further questions, Your Honor.

MR. COSTILO: Your Honor, I believe Dr. Rundles has been identified but not his first name. I think for the record if the witness knows his full name, it would be helpful.

THE WITNESS: William Rundles.

MS. MALESTER: Your Honor, we have no further questions for the witness, but at this point we would like to introduce Complaint Counsel's Exhibit 2206-A and B. It's a copy of the accusation filed by the State Board of Medical Quality Assurance against William Robert Rundles, M.D.

JUDGE BARNES: We'll receive Commission's Exhibits 2206-A and B. Do you have any objection?

MR. YOULE: We have no objection. But in light of this exhibit, I would like to ask the witness one more question.

By Mr. Youle:

Q. To the best of your knowledge, is Dr. Rundles still practicing medicine?

[6871] A. Dr. Rundles gave me a phone call about three months ago. He told me he was in Atlanta, Georgia. He was very sorry about what happened to my daughter. He wanted to talk and I told him that I wasn't up to talking. So he left his phone number for me to call him if ever I needed to talk to him, wanted to talk to him about anything.

Q. Do uou know whether he is still practicing in Georgia?

A. I'm not sure.

MR. YOULE: No further questions.

JUDGE BARNES: I'll receive Commission's Exhibits 2206-A and B.

(The documents referred to were marked Commission's Exhibits Nos. 2206-A and B for identification and were received in evidence.)

JUDGE BARNES: Have you taken any steps to discuss this with an attorney?

THE WITNESS: Yes.

JUDGE BARNES: Any further questions?

MR. YOULE: No, Your Honor.

MS. MALESTER: No further questions, Your Honor. Thank you very much.

JUDGE BARNES: Thank you.

(Witness excused.)

Examples of Physician Advertising

RX 922
Los Angeles Times, April 16, 1978

"I'm a new woman! A new figure!"

"Cosmetic Surgery was one of my best decisions of my life. Here's my figure now. My husband & I are really satisfied with my new appearance"

Enhance your bustline, modify your nose, face, and body contours, restore hair. Greater self-confidence, an increased feeling of well-being and a more exciting life are possible when you look your best. Learn why so many have selected our facility and Board Certified Surgeons after careful comparisons. Your free private consultation and brochure explain the surgery and anesthesia.

E. B. Frankel, M.D.

Member of American Medical Association
Assistant Board Certified Cosmetic Surgeons
Associated Dermatologists
AUTHOR OF "HAIR TRANSPLANTS – ADDITIONAL OBSERVATIONS"
PUBLISHED IN "CUTIS", A DERMATOLOGY MEDICAL JOURNAL

Encino, 16530 Ventura Blvd., Suite 314	213/990-4980
Los Angeles, 4322 Wilshire Blvd.	213/938-2191
Lakewood, 5203 Lakewood Blvd.	213/531-7420
Huntington Beach, 8101 Newman, Suite C	714/540-6605
Santa Ana, 2700 N. Main #932	714/541-6651
San Diego, 3031 Bunker Hill St., Suite 101	714/483-1900

Dr. Frankel, I understand you can help me. Please send me the following information:

☐ Cosmetic Surgery ☐ Dermatology
☐ Hair Transplantation

NAME _____

ADDRESS _____

CITY _____ STATE _____

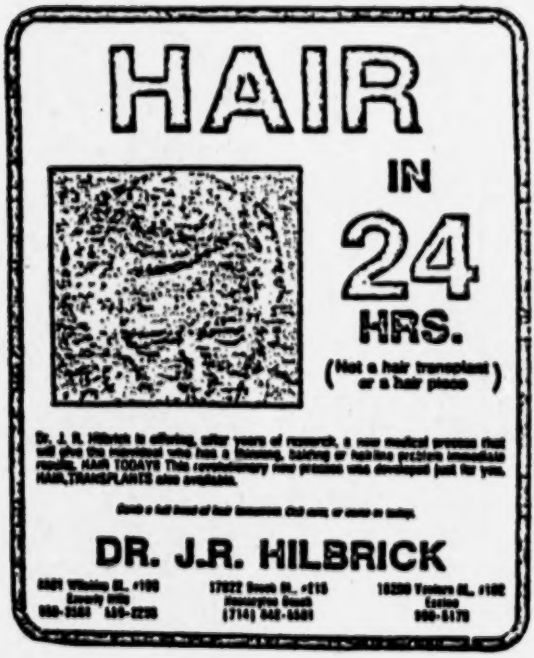
ZIP _____ PHONE ( ) _____

RX 268
Los Angeles Times, July 3, 1977

RX 877
(undated)

RX 801
San Diego Evening Tribune (November 17, 1977)

RX 920
Los Angeles Times (April 13, 1978)



RX 808 (undated)

RX 809
T.V. Guide
(undated)